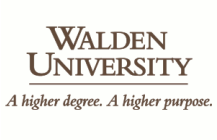

2016

The Impact of Religiosity and Gender on Attitudes Toward Juvenile Sex Offenders

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2016

Abstract

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by

Angela Barteau

MS, Walden University, 2013

BS, University of Arizona, 1991

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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March 2016

Abstract

Personal characteristics of mental health professionals can impact their attitudes toward juvenile sex offenders (JSOs) and affect treatment. The correlation between mental health professionals' religiosity and their attitudes has not been examined, and there is limited research about the correlation between professionals' gender and attitudes. The purpose of this study was to examine how mental health professionals' religiosity and gender related to their attitudes toward JSO treatment. Labeling theory provided the theoretical foundation for this study. This theory posits that individuals label certain populations, such as sex offenders, as deviant and this labeling perpetuates a cycle of criminal behavior. Using a quantitative approach, 123 mental health professionals completed an Internet survey that included demographic information, the Santa Clara Strength of Religious Faith Questionnaire, and the Attitudes Toward Treatment of Sex Offenders survey. These served to identify gender and measure religiosity and attitudes toward JSO treatment. A hierarchical multiple regression analysis was then used to examine the research questions and hypotheses. There were no statistically significant findings about how participants' religiosity and gender relate to their attitudes toward JSO treatment. However, further analyses revealed that type of profession and race of the participants affected their attitudes toward treatment. The findings can guide training programs to educate professionals that personal characteristics may affect their attitudes toward treatment. The potential for social change is that professionals' increased awareness may improve treatment effectiveness, which might ultimately lower offenders' recidivism and increase protection for the public.

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Dedication

I would like to dedicate this dissertation to my husband, Glenn, whose continued encouragement, love, and support provided an incredible source of strength to complete my dissertation journey. I would also like to dedicate my work to my two children, Chandler and Colette, who inspire me to reach outside of my comfort zone and be a pursuer of knowledge. Although I know they disliked the many nights of leftovers and frozen dinners, they were gracious and understanding throughout the process.

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I want to thank my dear friends, Annette and Lisa, for your willingness to listen to my struggles about completing my dissertation and challenging me to put one foot in front of the other. To my brilliant friend, Leslie, thank you for your numerous, creative solutions to dissertation roadblocks. My extended family and friends were extremely patient and kind when I said "no" to many requests in order to complete this process – thank you, thank you, and thank you. Once again, you all taught me about sacrificial love and grace.

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Chapter 1: Introduction to the Study

Introduction

Juveniles commit approximately one-third of the reported sex offenses against minors (Finkelhor, Ormrod, & Chaffin, 2009). Research indicates that treatment provided to adolescent sex offenders decreases their recidivism to levels of those who have never engaged in inappropriate sexual behaviors (Finkelhor et al., 2009; Worling, 2012). Research also reveals that juvenile sex offenders are a heterogeneous population, and stereotypical attitudes held by the public and mental health field can hinder effective treatment approaches that can target the diverse needs of this population (Finkelhor et al., 2009; Worling, 2013). Stereotypical attitudes or beliefs about juvenile sex offenders are often that they are: (a) aroused by young children, (b) sexually violent, (c) delinquent or antisocial, (d) deceitful, (e) psychiatrically disordered, and (f) cannot be treated (Sahlstrom & Jeglic, 2008; Worling 2013; Worling & Langton, 2012).

Mental health professionals' attitudes or opinions can impact treatment (Carone & LaFleur, 2000; Jones, 2013; Nelson, Herlihy, & Oescher, 2002). This study examined the relationship between the attitudes held by mental health professionals toward juvenile sex offender (JSO) treatment and the professionals' gender and religiosity. Research on the impact of mental health professionals' gender on their attitudes toward JSO treatment has been limited to one study by Jones (2013), and the findings of this research were statistically insignificant. According to Salerno et al. (2010) and Skitka, Bauman, and Mullen (2004), the public's desire for JSO registration s may reflect an attitude of retribution and a need to protect morality. Research has yet to examine if mental health

professionals' religiosity influences their attitudes toward the treatment of JSOs. Understanding how these variables impact attitudes toward treatment can provide insight into the professionals' misconceptions about juvenile sex offender traits and how training for JSO treatment providers could improve their treatment approaches. Efficacious treatment can decrease recidivism and promote public safety (Nelson, 2007; Sahlstrom & Jeglic, 2008; Salerno et al., 2010).

Chapter 1 describes research about attitudes toward JSO's treatment. The problem and purpose of the study are identified, and the research questions and hypotheses are described. After discussing the theoretical framework, the nature of the study, the definitions, assumptions, limitations, and delimitations of the study are addressed. The significance of the study concludes Chapter 1.

Background

The majority of studies examining attitudes about sex offender treatment have focused on adult sex offenders, using the general public as participants in some studies and treatment providers/professionals in others (Jung et al, 2012; Mann & Barnett, 2013; Rogers, Hirst, & Davies, 2011; Sandhu & Rose, 2012; Sanghara & Wilson, 2006). Jung et al. (2012) discovered that many professionals believe that adult child molesters are more likely to recidivate than rapists and exhibitionists, even though research has demonstrated that exhibitionists are more likely to reoffend than child molesters and rapists. Laypersons reported they believe exhibitionists are the least likely to reoffend sexually, which is contrary to current research findings (Jung et al., 2012). Treatment providers and the public also believe that an essential element of treatment for sex

offenders is encouraging empathy for their victim(s), and that this element helps decrease recidivism (Mann & Barnett, 2013). However, there is not enough empirical data to suggest that this is a beneficial element of treatment or that a lack of empathy for their victims can increase recidivism among sex offenders (Mann & Barnett, 2013). There is research that indicates that when therapists practice empathy in treatment, a parallel process occurs, allowing the offender to experience more empathy for their victims (Sandhu & Rose, 2012).

Current literature concerning the public and mental health professionals' attitudes about adolescent sex offenders' personal characteristics and treatment efficacy is scant. The general public and many mental health professionals assume that JSOs have more extensive criminal histories, drug use/abuse patterns, and antisocial peers than nonsexually abusive juvenile delinquents reoffend (Sahlstrom & Jeglic, 2008; Seto & Lalumiere, 2010). The public and mental health professionals also believe that JSOs will likely reoffend (Sahlstrom & Jeglic, 2008; Seto & Lalumiere, 2010). Such beliefs lead to more punitive approaches to JSO offending, such as decreased treatment services and increased periods of incarceration, rather than focusing on rehabilitation (Salerno et al., 2010; Worling, 2012; Worling & Langton, 2012).

A meta-analysis conducted by Seto and Lalumiere (2010) revealed that nonsexually offending youth are more likely to abuse illegal drugs/alcohol, socialize with delinquent peers, and are more likely to commit criminal offenses than JSOs. The public and professionals also assume that JSOs are more sexually deviant (e.g. aroused by pre-pubescent children), psychiatrically disordered, and deceitful than nonsexually delinquent

youth (Worling, 2012). Research has demonstrated that, contrary to these beliefs, not all JSOs are sexually deviant (Worling, 2013). Many JSOs are forthcoming about their sexual arousals and crimes, and many are diagnosed with fewer psychiatric disorders than nonsexually offending juvenile delinquents (Seto & Lalumiere, 2010; Worling, 2012).

These findings indicate that treatment should be individualized for the JSO, and focusing on the needs of each JSO might increase treatment effectiveness (Worling, 2012; Worling & Langton, 2012). JSOs who receive treatment are less likely to reoffend than nonsexually abusive juvenile delinquents and adult sex offenders (Nelson, 2007; Sahlstrom & Jeglic, 2008; Salerno et al., 2010).

Although limited, the more current research of attitudes toward JSO treatment has evaluated how the variables of the professionals' personal abuse history, gender, training, and years of experience impact these attitudes. Research by Carone and LaFleur (2000) revealed that student counselors' personal abuse impacted the type of JSOs with whom they wanted to work. Counselors with sexual abuse histories and those without sexual abuse histories preferred to work with JSOs who were victims of sexual and/or physical abuse than JSOs without any abuse backgrounds (Carone & LaFleur, 2000). However, counselors in training who were victims of sexual abuse preferred to work only with JSOs who were physically abused (Carone & LaFleur, 2000). Although not statistically significant, one research study discovered that male professional treatment providers expressed more positive views about JSOs' capacity to change than female providers (Jones, 2013). Other research has indicated that years of experience and training

promotes positive views of JSOs' personal qualities and improves treatment success (Nelson et al., 2002).

These studies reveal that mental health professionals' personal characteristics do impact their attitudes toward and treatment of JSOs. Gender's impact on attitudes and treatment remains divided, and the religiosity of mental health professionals is an unexplored variable. Research on the effects of mental health professionals' gender on attitudes toward adult sex offender treatment has been inconclusive (Ferguson & Ireland, 2006; Nelson, 2007; Tyagi, 2006). To the researcher's knowledge, only one study has analyzed how mental health professionals' gender impacts attitudes toward JSO treatment. Results from Jones (2013) did not reveal statistically significant differences between genders, but minor differences were detected.

How morality or religiosity impacts mental health professionals' attitudes toward JSO treatment has not been examined. A violation of one's beliefs concerning what is right and what is wrong leads to moral outrage (Salerno et al., 2010; Skitka, Bauman, & Mullen, 2004). The public's desire for registry laws for JSOs may reflect their desire for retribution against JSOs and a need to protect public morality, rather than reflect an interest in rehabilitation (Salerno et al., 2010; Skitka et al., 2004). When examining therapeutic relationships with other treatment populations, Crook-Lyon and Frietas (2010) and Farkas (2014) described the importance of therapists' awareness of how their religiosity impacts their treatment delivery. Therefore, understanding the effects of a mental health professional's religiosity could provide insight into how professionals' beliefs may impact attitudes toward treatment. Examining if these variables are

correlated with attitudes toward JSOs extends the research of how personal characteristics may impact overall assessment and treatment of JSOs.

Problem Statement

Public policy, such as registration and notification, for adult sex offenders has influenced laws regarding JSOs (Sahlstrom & Jeglic, 2008; Worling & Langton, 2012). Due to the mass media focus on sexual crime, much of the public desires punishment and lengthy sentences over treatment for adult sex offenders, unaware that treatment can help reduce recidivism (Church, Sun, & Li, 2011; Worling, 2013). Many individuals do not believe that treatment is effective or that offenders can make positive changes (Church et a., 2011). Because of the public demand for constant monitoring of adult sex offenders, sex offender registry and notification laws were enacted by state and federal legislatures (Conely, Hill, Church, Stoeckel, & Allen, 2011; Stevenson, Sorenson, Smith, Sekely, & Dzwairo, 2009). Opinions about the ineffectiveness of adult sex offender treatment have been transferred to opinions about JSOs, leading to pressure for JSO registration and public notification that relay information about any juvenile sexual perpetrator (Stevenson et al, 2011; Worling, 2013; Yoder, 2014). Mandatory registration and notification can increase risk of recidivism because the JSOs and their families become isolated from the social and community support that promotes healthy cognitions and behaviors (Worling, 2013; Yoder, 2014).

While protection of the public is imperative, the goal of the juvenile justice system is to rehabilitate individuals (Sahlstrom & Jeglic, 2008). Research has demonstrated that treatment focused on rehabilitation decreases recidivism more among

the JSO population than other types adolescent offenders (Calleja, 2013; Cochrane, 2010; Waite, Keller, & McGarvey, 2005). However, clinician's approach to treatment with any deviant population can affect the quality of the services provided, and attitudes and beliefs can negatively impact the approach to treatment (Jones, 2013; Nelson, 2007; Wakefield, 2006; Worling & Langton, 2012). A positive therapeutic relationship is necessary for an adolescent's successful treatment and response to change (Carone & LaFleur, 2000; Jones 2013; Worling, 2012). Mental health care professionals providing JSO treatment need training to understand their own beliefs, uncover their own misconceptions, and recognize efficacious approaches for building a therapeutic alliance with this population (Worling, 2012).

Although extensive research about perceptions of adult sex offender treatment exists, fewer studies have focused on attitudes toward treating JSOs. More importantly, studies about the beliefs of mental health care workers toward this population are limited (Carone & LaFleur, 2000; Nelson, 2007; Jones, 2013). Most current research has used student populations as participants rather than using more experienced mental health professionals (Carone & LaFleur, 2000; Cochrane, 2010). Correlations between mental health care workers' beliefs/opinions about JSO treatment and such variables as their years of experience, training, age, and personal victimization have been studied previously (Carone & LaFleur, 2000; Ferguson & Ireland, 2006; Jones, 2013; Nelson et al., 2002). However, research concerning the relationship between mental health care workers' beliefs about JSO treatment and their religiosity is nonexistent.

This variable was examined in this study because many individuals desire retribution toward JSOs, rather than rehabilitation, and therapists' own religious/spiritual background could impact their approach to treating JSOs (Beatty et al., 2007; Bidell, 2014; Crook-Lyon & Frietas, 2010; Salerno et al., 2010). Although the relationship between therapists' gender and attitudes toward adult sex offender treatment has been evaluated (Ferguson & Ireland, 2006; Nelson, 2007; Tyagi, 2006), only one study has examined the impact of gender on attitudes toward JSO treatment (Jones, 2013). Gaining insight into these potential correlations could add to the existing literature about the relationship between personal characteristics of mental health care workers and their beliefs/attitudes toward JSO treatment (Nelson et al., 2002; Kimonis, Fanniff, Borum, & Elliott, 2011; Worling & Langton, 2012).

Purpose

The purpose of this correlational survey study was to examine the relationship between mental health care professionals' religiosity and their attitudes toward JSOs, as well as the relationship between mental health professionals' gender and their attitudes toward JSOs. Attitudes about JSOs are defined by the responses from the Attitudes Toward the Treatment of Sex Offenders (ATTSO) survey (Wnuk, Chapman, & Jeglic, 2006), and religiosity is defined by responses from the Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ; Plante & Boccaccini, 1997a). The researcher hoped to determine if a relationship exists between mental health professionals' religiosity and their attitudes toward JSOs, and mental health professionals' gender and their attitudes toward JSOs.

Research Question and Hypotheses

The author wanted to understand if there is a relationship between treatment providers' attitudes toward JSOs and the variables of the providers' gender and religiosity. Therefore, the research questions and hypotheses for this proposed study included:

RQ1: Is there a relationship between the religiosity of mental health care professionals and their attitudes toward JSO treatment?

H_0: There is no relationship between mental health care professionals' spiritual/religious background/beliefs and their attitudes toward JSO treatment.

H_1: There is a relationship between mental health care professionals' religiosity and their attitudes toward JSO treatment.

RQ2: Is there a relationship between gender of mental health care professionals and their attitudes toward JSO treatment?

H_0: There is no relationship between the gender of mental health care professionals' and their attitudes toward JSO treatment.

H_1: There is a relationship between the gender of mental health care professionals' and their attitudes toward JSO treatment.

RQ3: Is the relationship between religiosity and attitudes toward JSO treatment moderated by gender?

H_0: The relationship between religiosity and attitudes toward JSO treatment is not modified by gender.

H_1: The relationship between religiosity and attitudes toward JSO treatment is

modified by gender.

A hierarchical multiple regression analysis was conducted to test all research questions and corresponding hypotheses.

Theoretical Framework

The theoretical framework for this study was based on labeling theory (also called social reaction theory), developed by Becker (1963). Labeling theory describes the process and outcomes of labeling others as deviant. This theory concentrates on who ascribes the label and to whom they ascribe it (Becker, 1963). Understanding why the label is ascribed and assessing the results from the label are the goals of labeling theory (Becker, 2963). Examples of individuals often labeled as deviant are alcoholics, criminals, drug addicts, psychiatric patients, and sex offenders (Becker, 1963). The more powerful individuals of society (e.g. police officers and politicians) label most of these individuals as deviant.

The deviant behaviors of the individuals are the primary means by which they are identified, and many people assume these individuals will become deviant again (Becker, 1963). Those individuals who are labeled deviant are rejected by others, reject themselves, suffer from lower self-esteem, and may resort to their deviant behaviors as a reaction to the label (Becker, 1963). Members of the society who internalize the label as a true description of the labeled person struggle to change their opinions about the labeled person, even when they are presented evidence that is contradictory to the information they have internalized (Becker, 1963).

Labeling theory provided the foundation for how individuals form potentially inaccurate opinions about sex offenders (Sahlstrom & Jeglic, 2008). . Inaccurate beliefs and being misinformed lead to stigmatizing attitudes (Markowitz, Angell & Greenberg, 2011). Many individuals possess attitudes that most sex offenders recidivate, cannot be rehabilitated, and embody a specific type or persona.

Researchers have demonstrated that believing sex offenders are incapable of change and labeling sex offenders as deviant can increase the likelihood of recidivism and work against treatment goals (Linn, Grater, & Perersilia, 2010; Mingus & Burchfield, 2012; Wakefield, 2006). Because mental health professionals are directly involved in the therapy and treatment of JSOs, it is important to understand what attitudes they possess, labels they use, different personal variables that may relate to the labeling, and how these labels might impact treatment. Labeling theory and its relevance to this study are further explored in Chapter 2.

Nature of the Study

This was a correlational study. The researcher desired to determine if a relationship exists between mental health professionals' gender and their opinions about JSO treatment, and if a relationship exists between mental health professionals' religiosity and their opinions about JSO treatment. This study also examined if the relationship between religiosity and attitudes toward JSO treatment is moderated by gender. Surveying mental health care workers was consistent with quantitative approaches. The Santa Clara Strength of Religious Faith Questionnaire (SCSRFQ; Plante & Boccaccini, 1997) was used to measure the mental health care workers' religiosity. A

demographic questionnaire was used to identify the gender of the mental health care professional. The Attitudes Toward the Treatment of Sex Offenders (ATTSO; Wnuk et al., 2006) measured mental health care workers' beliefs about JSOs. According to Creswell (2014), survey instruments can produce more objective, quantitative findings. These findings can provide a basis from which to analyze how the personal characteristics of religiosity and gender are related to beliefs about adolescent sex offender treatment. A hierarchical multiple regression was conducted to analyze all research questions and hypotheses.

Only individuals currently practicing in the mental health field participated in the online survey. Mental health professionals included counselors/therapists, psychologists, social workers, school psychologists, psychiatrists, and behavioral health providers. Results from the survey were electronically submitted on a secure server through Survey Monkey. The researcher used all complete Internet surveys in the hierarchical multiple regression analysis.

Definitions

Attitudes toward juvenile sex offender treatment were operationally defined as scores from the ATTSO (Wnuk et al., 2006). The ATTSO measures an individual's attitudes or emotions toward the treatment of sex offenders, such as mandatory treatment or treatment effectiveness (Wnuk et al., 2006). Scores range from 35-175, with higher scores indicating more negative attitudes concerning the efficacy of treatment (Wnuk et al., 2006).

Gender was operationally defined as how participants identified themselves - male or female.

Juvenile Sex Offender (JSO) was defined as any youth between the ages of 12 and 18 who has been convicted of a sexual offense. Illegal sexual behaviors (offenses) include: voyeurism, obscene phone calls, exhibitionism, oral copulation, inappropriate or illegal fondling, frottage, and penetration of the vagina or anus by the penis or other object.

Mental health care workers were operationally defined as those individuals who are state-licensed psychologists, counselors/therapists, social workers, school psychologists, psychiatrists, and behavioral health providers.

Religiosity was operationally defined using scores from the SCSRFQ (Plante & Boccaccini, 1997). Because religion and religious faith impact human behaviors, Plante and Boccaccini (1997) designed the SCSRFQ to measure individuals' strength of religious faith independent of their denomination or affiliation to a religious group. Higher scores on the SCSRFQ indicate higher levels of religious faith (Plante & Boccaccini, 1997).

Assumptions

The assumption of this research study was that participants would answer the demographic questionnaire, the ATTSO (Wnuk et al., 2006), and the SCSRFQ (Plante & Boccaccini, 1997) honestly. Factors that may have impacted honesty may include: the participant's mood when taking the survey, where the participant takes the survey, and if the survey is anonymous or confidential (Ahern, 2005). Although the researcher could

not control participants' mood or location of survey, the survey was anonymous. In addition, response bias could have been impacted by how participants interpreted the questions. The researcher also assumed that the ATTSO accurately assessed attitudes and the SCSRFQ accurately measured religiosity. These assumptions were necessary in order to effectively examine the attitudes held by the participants.

Scope and Delimitations

The focus of this study was how mental health professionals' religiosity and gender relate to attitudes toward JSO treatment. Other cognitive, social, demographic, etc. variables of mental health professionals have been analyzed in past research, including race, type of profession, and years of experience; therefore, these variables were not the focus of this study. Past studies have also compared the attitudes of mental health care professionals with students and correctional employees; however, the researcher desired to focus on mental health care professionals because of their direct effect on treatment. Prior studies investigating attitudes toward sex offender treatment have focused on how individuals' opinions are impacted by information from the media or public policy, but many of these studies lack a theoretical framework on which to base findings. This study focused on the affect of mental health professionals' gender and religiosity on their attitudes toward JSO treatment and examined these attitudes through the theoretical lens of labeling. Recruitment focused on professionals in Arizona. This limits the study's findings to those produced primarily by mental health professionals residing in Arizona, restricting generalizability. Finally, this study was limited to the time period in which the data was collected and processed. Attitudes of the mental health

professional participants could have changed from the time the data were collected and processed to when the dissertation was completed.

Limitations

A threat to generalizability may have resulted from unintentionally limiting potential participants to those who understand how to navigate and have access to the Internet. Potential participants were automatically eliminated if they could not access the Internet or did not understand how to use the Internet. Additionally, there may have been some participants who could access the Internet and have some knowledge of how to use it, but limited knowledge of usage could have hindered their ability to gain access to the survey link. These limitations could have created selection bias (Ahern, 2005). In addition, due to the sensitive nature of the survey content, some potential participants could have chosen not to complete the survey, which could have created self-selection bias (Laerd Dissertation, 2012).

The self-report nature of the instruments could have resulted in social desirability bias. Some individuals desire to answer questions in a way they believe is the most socially acceptable (Krumpal, 2013). This is especially true when the content of the questions/items are more personally or socially sensitive, such as illegal behaviors, racism, and sexual behaviors (Krumpal, 2013). Because the content of this research focused on sexual offending, social desirability bias could have been problematic. However, anonymous survey methodology can decrease social desirability bias (Ahern, 2005).

The researcher could not determine causation because of the correlational design. Correlational analyses examine a relationship between two variables, which can be impacted by other outside variables (Field, 2013). Because the nature of correlational analyses does not allow the researcher to determine which variable caused the other to change, I could not determine the direction of causality (Field, 2013). However, the hierarchical regression analysis provided information about the moderating affect of gender on the relationship between mental health professionals' religiosity and their attitudes toward JSO treatment.

Finally, the nature of the Internet survey did not allow the researcher to control who completed the survey, the testing environment, or the privacy of the data (Ahern, 2005). Although the researcher sent the survey invitation and link only to identified mental health professionals, other individuals may have completed the survey. The participants may have filled out the survey in an environment that limited concentration or in which they felt exposed to the public, which could have led to inaccurate reporting. The researcher took the necessary steps to ensure the privacy and anonymity of the participants and their surveys, but the participants may not have protected their privacy while they completed the survey.

Significance

This study provided insight into how mental health care workers' gender and religiosity related to their beliefs about JSOs. Findings from this study could potentially influence training programs designed to increase mental health care professionals' awareness about the most commonly held beliefs about JSO treatment. These training

programs could address misconceptions, negative attitudes and labels, and potential personal attributes of the professionals that often impact their attitudes toward treatment. The training could also incorporate current research to support effective treatment approaches and how attitudes or labels negatively impact the therapeutic relationship and treatment success. This would provide a more objective position from which professionals could approach treatment. Building a healthy therapeutic relationship and treatment approach could enhance adherence to treatment programs and thereby potentially decrease recidivism (Jones 2013; Waite et al., 2005; Worling, 2012).

Summary

Treatment of adolescent sexual offending has proven to be effective and decreases recidivism rates (Cochrane, 2010; Finkelhor et al., 2009; Waite et al., 2005). However, the effectiveness of treatment relies on the therapeutic relationship (Carone & LaFleur, 2000; Jones 2013; Worling, 2012), and negative attitudes or stereotypes of treatment providers can negatively affect this relationship (Jones, 2013; Nelson, 2007; Wakefield, 2006; Worling & Langton, 2012). Mental health professionals treating JSOs must understand their own attitudes and how those attitudes are shaped (Worling, 2012). Past research has investigated how mental health professionals' level of experience, training, experience of personal sexual abuse, race/ethnicity, and age impact their attitudes and beliefs (Carone & LaFleur, 2000; Ferguson & Ireland, 2006; Jones, 2013; Nelson et al., 2002). The exploration of how mental health professionals' genders and religiosity are related to their attitudes toward JSOs can contribute to the current literature.

Chapter 2 introduces the literature review and highlights the strategies used to search the literature. The review includes a discussion about labeling theory, JSO treatment, mental health professionals' attitudes, and mental health professionals' religiosity and gender.

Chapter 2: Literature Review

Introduction

The beliefs and attitudes about adult sex offenders are that they cannot be rehabilitated, they will reoffend, and that they should be punished rather than receive treatment (Church et al., 2011; Sun et al., 2011; Worling, 2013). Such attitudes have led to registration and notification laws (Conley et al., 2011; Worling & Langton, 2012). These beliefs and attitudes about recidivism have been carried over to JSOs, with much of the public believing that treatment ineffectiveness demands registration and notification for juvenile offenders (Stevenson et al., 2011; Worling, 2013; Yoder, 2014). However, the primary goal of the juvenile justice system is to focus on rehabilitating all offenders (Calleja, 2013; Pullman & Seto, 2012). Research shows that rehabilitation for JSOs is effective, and recidivism rates for JSOS who have experienced treatment are lower than juvenile non-sexual offenders who have received treatment (Calleja, 2013, Cochrane, 2010; Waite et al., 2005). The effectiveness of rehabilitation with any population requires that the service provider possesses a healthy therapeutic relationship with their client and maintain a positive approach to treatment (Jones, 2013; Worling & Langton, 2012). Successful treatment of JSOs is also dependent on these elements (Jones, 2013; Worling, 2012). To maximize their ability to establish a healthy bond and provide effective treatment, mental health professionals must become aware of their own misconceptions and negative attitudes (Worling, 2013).

Research indicates that spiritual/religious therapists may build better therapeutic alliances because they are often higher in agreeableness, and they may provide more

competent treatment services because of their conviction that individuals should be held accountable for their behaviors (Cummings, Ivan, Carson, Stanley, & Paragment, 2014; Kellems, Hill, Crook-Lyon, & Frietas, 2010). However, counselors and therapists with more fundamental religious backgrounds may be more verbally aggressive in an effort to convey or impose their beliefs during therapy. These individuals may struggle to form a therapeutic bond with clients of different belief systems or values (Cummings et al., 2014). A meta-analysis of spirituality/religiosity and therapists revealed that those with more conservative spiritual/religious backgrounds are less supportive and possess negative attitudes toward those who are engaged in unconventional sexual activities (Cummings et al., 2014). As of this date, the author has been unable to discover research about the religious background of therapists or counselors and their attitudes toward JSOs.

Researchers have investigated how therapists' gender affects attitudes toward clients, therapeutic relationships, and treatment outcomes (Artkoski & Saarnio, 2013; Greeson, Guo, Barth, Hurley, & Sisson, 2009; Owen, Duncan, Resse, Anker & Sparks, 2014). However, this research pertains to populations other than JSOs. The relationship between a therapist's gender and attitudes toward sex offenders has been evaluated but remains divided (Ferguson & Ireland, 2006; Jones, 2013; Nelson, et al., 2002; Tyagi, 2006). The research findings from Jones (2013) did not reveal any differences between male and female therapists' attitudes toward JSOs, and Nelson et al. (2002) discovered no significant gender differences in counselors' attitudes toward adult sex offenders. Ferguson and Ireland (2006) found that female forensic staff held more positive views of

adult sex offenders than male staff. However, some research indicates that female therapists struggle with negative feelings toward adult sex offenders, impacting the therapeutic alliance (Tyagi, 2006). Therefore, due to the nature of the sexual behaviors of JSOs and the importance of a healthy therapeutic relationship for treatment, these variables were further explored.

Chapter 2, the literature review, summarizes the literature search strategy and discusses the theoretical foundation of the study. Using past and current research, the literature review also addresses the treatment of juvenile sex offenders, attitudes of mental health professionals toward JSOs, and the impact of mental health professionals' gender and religiosity on attitudes, therapeutic relationships, and treatment.

Literature Search Strategy

This literature review used the following databases: Sage, Ebsco, Thoreau, ProQuest Central, PsychInfo, Academic Search Complete, Google Scholar, ERIC, SocIndex, and PsychArticles. Some of the key terms for the searches included: *sex offender, adolescent(s) sex offender, juvenile(s) sex offender, youth sex offender, mental health care professional, counselor, professional, treatment provider, psychologist, therapist, psychiatrist, social worker, belief, opinion, attitude, misconception, and assumption.* Other key words associated with the search included *labeling theory, CATSO survey, recidivism, gender, spirituality, religion, religiosity, and therapeutic relationship.* Boolean phrases "and" and "or" were also incorporated in the searches. Initial searches were limited to peer-reviewed journals from the years 2010-2015;

however, the limited number of findings led to expanding the search to include the years between 2000-2015.

Theoretical Framework

Howard Becker's (1963) labeling theory provided the theoretical framework for this study. Becker (1963) described how individuals are labeled, who labels them, and the outcome of the labeling process. Many of society's outcasts, such as criminals, drug addicts, psychiatric patients, and sex offenders, are labeled as "delinquent" or "deviant" (Becker, 1963; Markowitz, Angell, & Greenberg, 2011; Moore & Morris, 2011). According to Moore and Morris (2011), individuals in government institutions and those in political power ascribe delinquent or deviant labels, and this labeling impacts society's views and the political agenda of those in power. Labeling theory posits that those in positions of power use labels as a means to control those in lower societal positions (Moore & Morris, 2011).

Understanding why labels are ascribed and examining the results from the labeling are other elements of labeling theory (Becker, 1963). Once an individual is labeled, the deviant behaviors of the individual become the primary means by which they are identified (Young & Thompson, 2011), and many people assume the individual will become deviant again (Becker, 1963). Individuals who are labeled deviant are rejected by society. While some researchers argue that the "deviant" label may promote an individual's desire to make positive changes (Hayes, 2010), many people internalize the label, reject themselves, suffer from low self-esteem, and may recidivate in reaction to the label (Markowitz et al., 2011; Moore & Morris, 2011). The theory posits that those in

society who accept and use these labels struggle to change their opinions of a labeled person, even when they are presented evidence to the contrary (Becker, 1963).

Labeling theory provided the foundation of how individuals form opinions and attitudes about sex offenders – attitudes that are potentially inaccurate (Moore & Morris, 2011; Sahlstrom & Jeglic, 2008). Individuals may inaccurately assume that most sex offenders cannot be rehabilitated, recidivate, embody a specific type or persona, or are a part of a homogenous group of individuals (Church et al., 2011; Cochrane, 2010; Rogers, Hirst, & Davies, 2011; Sun et al., 2011; Worling, 2013). Studies have demonstrated that these stereotypical attitudes lead to labeling adult or juvenile sex offenders as deviant and incapable of change, which works against treatment goals and increases the likelihood of recidivism (Blomberg & Bales, 2012; Linn, Grater, & Perersilia, 2010; Mingus & Burchfield, 2012). Because mental health professionals are directly involved in the therapy and treatment of juvenile sex offenders, it is important to understand what attitudes they espouse about treatment effectiveness and recidivism, and how their labels might negatively impact treatment (Jones, 2013; Worling & Langton, 2012).

Labeling theory may help explain the relationships between mental health care professionals' religiosity and gender and their attitudes toward JSO treatment. More fundamental or conservative spiritual/religious mental health care workers can carry more negative attitudes toward individuals with deviant or unconventional sexual behaviors (Cummings et al., 2014), and these attitudes may lead to labeling JSOs as incapable of change despite treatment. Because the research about the correlation between gender and attitudes toward sex offender treatment effectiveness is conflicting, labeling theory may

illuminate why differences of the gender variable exist. The professionals' attitudes about JSO recidivism and rehabilitation may lead to labeling JSOs as incapable of positive therapeutic change, which negatively impacts the therapeutic relationship and treatment delivery.

Literature Review Related to Key Variables and Concepts

Treatment Approaches for JSOs

Research on the treatment of adult sexual offenders has shaped the treatment of JSOs (Calleja, 2013; Yoder, 2014). Because cognitive behavioral interventions and relapse prevention are effective methods used for treating adult offenders, treatment providers have used these methods for JSOs in individual, family, and group therapy (Calleja, 2013; Letourneau et al., 2013; Rasmussen, 2012). Cognitive behavioral treatment (CBT) challenges adolescents to identify cognitive distortions related to their sexual behaviors and thoughts that incite dysfunctional behaviors (Yoder 2014). These thoughts are challenged, and positive, healthy thoughts (including a focus on empathy) are promoted (Calleja, 2013; Letourneau et al., 2013; Yoder, 2014). Relapse prevention focuses on identifying triggers and situations that may cause relapse and developing new coping strategies (Calleja, 2013; Halse et al., 2012; Yoder, 2014). Treatment providers using relapse prevention emphasize its importance for offenders who complete treatment and are reintegrated into society (Calleja, 2013; Yoder, 2014).

While research indicates that CBT and relapse prevention can be effective for some JSOs (Ikomi et al., 2009; Pullman & Seto, 2012), the treatment needs of sexually abusive youth differ significantly from adult sex offenders because of the adolescent

developmental changes and the influence of multiple systems (e.g. school, friends, family, work) in which they are a part (Halse et al., 2012; Letourneau et al., 2013; Yoder, 2014). Due to the lack of a fully developed prefrontal cortex, adolescents often struggle with impulsivity and the ability to identify potential long-term consequences for their actions (Calleja, 2013). Treatment efficacy may improve when brain development and its effects on impulsive decision-making (e.g. substance abuse, delinquent decisions) are considered. Consideration of these issues allows treatment to focus on age-appropriate education, skill development, and the expansion of positive support systems (Calleja, 2013).

In addition, researchers and treatment providers are now emphasizing the effectiveness of multisystemic therapy (MST) for treating sexually abusive youth (Halse et al., 2012: Letourneau et al., 2013; Pullman & Seto, 2012; Yoder, 2014). Adolescents are heavily influenced by their interactions with family, peers, school environment, and local communities (Yoder, 2014). MST trains family members how to relate in functional and healthy ways, and it identifies negative and positive social networks and interactions of the youth (Halse et al., 2012; Letourneau et al., 2013; Pullman & Seto, 2012). By focusing on creating healthier systems for the adolescent, reentry into society may be more successful and recidivism may be reduced (Calleja, 2013). In a two-year follow-up study, Letourneau et al. (2013) demonstrated that JSOs treated with MST reported less delinquency and problematic sexual behaviors than those treated with CBT.

Regardless of the treatment approach, JSOs need a safe and supportive environment that emphasizes positive factors for rehabilitation (Calleja, 2013). A strong

therapeutic alliance, characterized by positive regard and acceptance, promotes a safe environment for the youth to disclose unhealthy behaviors and thoughts and learn healthier, more adaptive ones (Calleja, 2013; Halse et al., 2012). Halse et al. (2012) reported that positive interactions with therapists allowed the JSOs to decrease feelings of shame, improve self-esteem, experience a model of a healthy relationship, and gain awareness of their maladaptive behaviors and cognitions.

Mental Health Professionals' Attitudes Toward Juvenile Sex Offender Treatment

Approaches to treatment and therapeutic relationships are impacted by beliefs and attitudes, regardless of whether these beliefs are supported empirically or not (Worling, 2013). Prior to the 1980s, professionals believed treatment for juvenile sex offenders (JSOs) should be individualized due to the differentiating factors that impact each youth's behaviors and cognitions (Worling, 2013). The goal of the juvenile justice system was to rehabilitate, and the predominant belief was that adolescents could change given the right treatment (Worling, 2013). The consensus was that JSOs were a heterogeneous group; therefore, it was believed that they should be assessed and treated as such (Worling, 2013).

Beginning in the 1980s, the public was learning that many adult sex offenders began offending in their youth. This knowledge led to the belief that juvenile sex offense rates were higher than recorded (Cheung & Brandes, 2011), that these behaviors were ingrained, and that recidivism was inevitable (Jung, Jamieson, Buro, & Descare, 2012; Worling, 2013). As a result, the public desired more punitive measures for JSOs, and public policy called for more lengthy, intense, and shameful approaches to treatment

(Kimonis, Fanniff, Borum, & Elliott, 2010; Worling & Langton, 2012). Most of the public and many treatment professionals believed that such approaches would improve treatment response, decrease recidivism rates, and protect the public (Jung et al., 2012). Chaffin (2008) stated that such measures may have been a result of seeking retribution or desiring to deter other youth from committing the same crimes. In addition, most states across the country adopted the policy that JSOs must register as a result of Megan's law (Caldwell & Dickinson, 2009; Cochrane, 2010).

Treatment approaches were based on public assumptions, and some of these assumptions persist today without scientific data to support them. Many believed that JSOs were a homogenous group (Ikomi, Harris-Wyatt, Doucet, & Rodney, 2009), were more likely to reoffend than juvenile non-sex offenders, possessed more deviant proclivities (e.g. attraction to young children), and lacked the necessary character, resiliency, and social strengths to ensure lasting positive change (Chaffin, 2008; Worling, 2013). However, research has demonstrated that JSOs are a heterogeneous population due to the multiple combination of factors leading to their behavior, including: their degree of deviancy, age of initial offending, personal victimization (physical, emotional, and/or sexual abuse), substance use/abuse (or non-use), number of age appropriate peer relationships, other criminal activity (or lack thereof), and family/home environment (violent/unhealthy versus safe/supportive) (Fortney & Baker, 2009; Ikomi et al., 2009). All of these factors impact the JSOs behaviors and cognitions, but with appropriate treatment, most are less likely to recidivate than non-sexual juvenile offenders (Cochrane, 2010; Conley et al., 2011; Fortney & Baker, 2009; Jung et al., 2012).

Some mental health professionals continue to believe that JSOs are a homogenous group, difficult to treat, likely to reoffend, and require punitive treatment to unearth psychopathological schemas (Chaffin, 2008; Jones, 2013). However, others believe that JSOs can effectively respond to treatment geared toward their developmental, social, and environmental needs (Salerno et al., 2010). Beliefs that JSOs are deceitful, deviant, and pathological can inhibit a therapist's ability to build a healthy and positive therapeutic relationship (Worling & Langton, 2012). Focusing on the adolescent's positive factors can advance treatment, and establishing a healthy therapeutic bond can improve treatment outcomes (Jones, 2013; Worling & Langton, 2012). Kimonis et al. (2010) and Chaffin (2008) stated that the juvenile justice system's focus on treatment amenability should guide JSO treatment because it can promote pro-social behaviors and decrease recidivism rates. Pro-social behaviors are enhanced when JSOs receive positive interactions with adults, such as their parents and therapists (Cheung & Brandex, 2011), and when these interactions are empathic rather than punitive (Kimonis et al, 2010).

Assessments of a JSO's future risk and treatment needs guide the courts' decisions, and approaches to treatment impact treatment efficacy. Therefore, mental health care professionals would be prudent to examine how they assess and treat JSOs, and they should evaluate the factors that can impact this process (Fortney & Baker, 2009; Ikomi et al., 2009; Kimonis, et al., 2010; Jones, 2013). Past research has revealed that public opinion and the sex offender's victim characteristics influence mental health provider's attitudes toward treatment (Jung et al., 2012; Sahlstrom & Jeglic, 2008; Salerno et al., 2010). Providers' attitudes and treatment approaches are also impacted by

the offender's type of crime, alcohol use, and level of denial (Jung et al., 2012; Sahlstrom & Jeglic, 2008; Salerno et al., 2010). The provider's training, victimization, and level of experience are some of the other factors that affect opinions and treatment methods (Jones, 2013; Kimonis et al., 2010; Nelson et al., 2002; Sandhu & Rose, 2012).

Impact of Mental Health Professionals' Gender

Mental health professionals' gender may impact attitudes and treatment outcomes. In a Finnish study, female therapists possessed more positive attitudes toward substance abuse clients than male therapists (Artoski & Saarnio, 2013). Female therapists also held more positive attitudes of homosexual clients (Artoski & Saarnio, 2013). Researchers hypothesize that such positive outlooks of female therapists could be due to a more empathetic and friendly approach toward the client (Artoski & Saarnio, 2013; Saarnio, 2010). Other studies have indicated that mental health professionals' gender does not significantly impact treatment outcomes for a variety of clinical needs (Okiishi et al., 2006; Owen et al., 2014; Wampold & Brown, 2005). However, Greeson et al. (2009) found that youth treated by female therapists in intensive in-home therapy were less likely to have negative/undesirable outcomes at a one-year follow-up.

Because treatment of sex offenders can be influenced by public opinion (Chaffin, 2008; Fortney & Baker, 2009; Ikomi et al., 2009; Worling, 2013), gender differences in public attitudes about treatment effectiveness should be assessed. Various studies have examined the influence of gender on public attitudes toward adult sex offender treatment but have been inconclusive. Rogers et al. (2011) found no gender differences in participants' attitudes toward the effectiveness of treatment for adult sex offenders. Male

and female respondents conveyed that they believe sex offender treatment could decrease recidivism and improve rehabilitation (Rogers et al., 2011). Using the Community Attitudes Toward Sex Offender Scale (CATSO; Church et al., 2008), Willis, Malinen, and Johnston (2013) demonstrated that female community participants from New Zealand possessed more negative attitudes about adult sex offenders' abilities to change than the male participants. Finally, a study recruited student and forensic staff participants to determine if differences existed between men and women in their attitudes toward treatment effectiveness (Ferguson & Ireland, 2006). Compared to student participants, forensic staff participants demonstrated more positive beliefs that sex offenders could be rehabilitated (Ferguson & Ireland, 2006). However, men were more likely to possess negative attitudes of sex offenders' ability to rehabilitate than women (Ferguson & Ireland, 2006). Results from these studies reveal that gender differences in public attitudes toward treatment effectiveness for adult sex offenders remain inconclusive.

Research of gender differences in public attitudes toward JSO treatment is more limited. Sahlstrom and Jeglic (2008) discovered no gender differences in attitudes about JSO treatment effectiveness among college-age participants enrolled in an introductory psychology course. Another study investigated the effects of participants' gender and race on attitudes toward JSO treatment and punishment/registration (Stevenson, Sorenson, Smith, Sekely, & Dzwairo, 2009). Women were more likely than men to support registration of the JSO as a form of punishment (rather than rehabilitation), particularly when the offender's victim was Caucasian (Stevenson et al., 2009).

Additionally, female participants expressed that the offender was more likely to recidivate when the offender's victim was Caucasian (Stevenson et al., 2009). However, the JSO's race did not significantly impact male or female participants' attitudes toward treatment or registration (Stevenson et al, 2009). The study by Stevenson et al. (2009) was also important because it revealed a difference between men and women in their attitudes toward rehabilitative treatment versus punishment of JSOs. As stated earlier, attitudes of retribution negatively impact treatment (Cochrane, 2010; Sahlstrom & Jeglic, 2008).

Because attitudes impact treatment efficacy, it is essential to understand gender differences in mental health professionals' attitudes toward sex offender treatment (Jones, 2013; Nelson, 2007; Worling, 2012). Although minimal, more extant literature has examined differences between genders of mental health professionals' attitudes toward treatment of adult sex offenders than JSOs. Nelson et al. (2002) did not discover any gender differences in counselors' attitudes toward the efficacy of treating adult sex offenders. However, Tyagi (2006) indicated that many female counselors struggled more with issues of countertransference when working with male sex offenders, and the female counselors questioned their ability to facilitate change. In contrast, another study found that female forensic staff held more positive views of sex offender treatment effectiveness than male staff members (Ferguson & Ireland, 2006).

Examining gender differences in mental health professionals' attitudes toward JSO treatment is difficult due to the lack of research. To examine general attitudes about JSOs, Jones (2013) targeted counselors employed in a residential treatment program for

his participant pool. Although the psychometric properties of the CATSO survey (Church et al. 2008) have only been established for assessing attitudes toward adult sex offenders, Jones (2013) used the instrument to assess participants' attitudes toward JSOs. Findings from the CATSO survey (Church et al., 2008) did not reveal a statistically significant relationship between the counselor's gender and their perceptions of JSOs (Jones, 2013). However, one of the four factors of the CATSO survey (Church et al., 2008), the "Capacity to Change" factor, assesses if the participant believes that rehabilitating sex offenders is worthwhile and if treatment can change sex offenders' behaviors. Although not statistically significant, male participants were slightly more positive than females on the Capacity to Change factor (Jones, 2013). Because this is the only article currently available about the impact of mental health professionals' gender on attitudes toward JSOs, these variables should be further explored.

Impact of Mental Health Professionals' Religiosity

Religious beliefs, attitudes, and backgrounds arguably are intertwined in multiple areas of individuals' lives (Beatty, Hull, & Arikawa, 2007) and drive individuals' behaviors. Therefore, it is essential to understand how mental health professionals' religion or spirituality impacts their approach to treatment and the therapeutic relationship (Balkin, Schlosser, & Levitt, 2009; Cummings et al., 2014; Farkas, 2014; Kellems et al., 2010). Beatty et al. (2007) and Bidell (2014) indicated that therapists must become aware of how their religious/spiritual background affects their ability to provide efficacious treatment and build a healthy relationship. This can be problematic when dealing with morally complex issues (Beatty et al., 2007; Bidell, 2014). When

spiritual/religious influences are ineffective, clients may become ashamed, hurt, or confused and terminate treatment prematurely (Beatty et al., 2007). Clients may also resist or deny clinical issues or reject the proposed intervention (Beatty et al., 2007). Harming clients and failing to exercise multicultural competence are violations of the American Psychological Association's Ethical Principles and Code of Conduct (APA, 2014). However, research also reveals that therapists' religion/spirituality may be beneficial to treatment and the therapeutic relationship (Kellems et al., 2010). Available research does not address correlations between mental health professionals' religiosity and their opinions about JSO treatment; however, there is literature that addresses how professionals' spiritual/religious beliefs and practices influence treatment with other treatment populations.

Mental health professionals must become self-aware of any stigma, prejudice, or label they may assign to clients. When a client's behaviors or presenting issues conflict with the mental health professional's religious beliefs, building a healthy therapeutic relationship and implementing effective practices may become problematic (Balkin et al., 2009; Bidell, 2014). Balkin et al. (2009) and Bidell (2014) indicated that many counselors with more conservative or fundamental religious/spiritual backgrounds struggle with stigmatizing the sexual behaviors of clients that do not align with their belief systems. Results from a study conducted by Balkin et al. (2009) revealed that counselors who espoused more fundamental religious beliefs displayed more homophobic and sexist attitudes, despite the ethical duty to become multiculturally competent. Bidell (2014) demonstrated that religious conservatism/fundamentalism

negatively impacted counselors' competency with sexual orientation. More conservative/fundamental religious counselors possessed more negative and prejudicial attitudes toward lesbian, gay, and bisexual clients and their treatment concerns (Bidell, 2014). Findings also revealed that awareness of these attitudes and biases was limited among those who held more conservative or fundamental beliefs (Bidell, 2014). Balkin et al. (2009) and Bidell (2014) argued that it is essential that counselors become self-aware of their attitudes, biases, and stigmas because a lack of awareness can limit therapy effectiveness.

Kellems et al. (2010) examined the impact of counselors' religious/spiritual practices on treatment and therapeutic relationships with their clients. Findings revealed that the majority of counselors were able to build strong therapeutic relationships with clients, regardless of the differences between their own religious commitments and the clients' religious commitments (Kellems et al., 2010). However, the findings revealed that there were variations in how the counselors' personal religiosity affected the treatment process (Kellems et al., 2010). Some counselors with strong religious goals and commitments used more religious treatment approaches, despite their clients' religious commitments (Kellems et al., 2010). These counselors were insensitive to the client's religious beliefs and failed to focus on the client's needs (Kellems et al., 2010). To protect the client, some counselors admitted that they needed to monitor their countertransference and reactions to client needs that were incongruent with their own religious/spiritual commitments (Kellems et al., 2010). When the counselor's religious commitments were congruent with the client's, the client experienced the treatment as

significantly beneficial (Kellems et al., 2010). The counselors described the importance of self-awareness about how their personal religious/spiritual commitment affects treatment (Kellems et al., 2010). They also emphasized the need to identify issues of countertransference or negative reactions that may result from their own religious commitments (Kellems et al., 2010).

A systematic review by Cummings et al. (2014) revealed that therapists' religious background did not significantly impact the therapeutic relationship, and treatment outcomes were similar for therapists with high and low religious commitments. However, therapists with higher religious values often interpreted their clients' behaviors through their own religious/spiritual lens (Cummings et al., 2014). When the behaviors of clients did not coincide with the therapists' belief systems, the therapists used their own religious institutional standards for judgment and guidance (Cummings et al., 2014). This was most problematic with clients' sexual behaviors (Cummings et al., 2014). Based on Cummings et al. (2014) findings, turning to society's opinion and guidance about treating the sexually "deviant" behaviors of JSOs may be problematic for therapists with stronger religious commitments. Further research must examine how the religiosity of mental health professionals affects their treatment approaches with JSOs (Cummings et al., 2014).

Summary and Conclusions

A review of the literature indicates that juvenile sex offenders are amenable to treatment and that recidivism is lower among JSOs than other juvenile offenders (Calleja, 2013; Cochrane, 2010). Treatment approaches that focus on rehabilitation instead of

retribution, such as multisystemic therapy, are more efficacious (Kimonis, Fanniff, Borum, & Elliott, 2010; Yoder, 2014). However, retribution and containment continue to be the public's predominant attitudes toward JSOs (Chaffin, 2008; Worling & Langton, 2012), and these attitudes may impact mental health care professionals' opinions and treatment approaches (Salerno et al., 2010; Worling, 2013). Treatment providers' negative attitudes or opinions can interfere with building healthy therapeutic relationships and impede efficacious treatment (Jones, 2013). Conversely, successful treatment is more likely when treatment providers believe that JSOs can be treated and when they establish healthy therapeutic interactions with the JSOs (Cheung & Brandex, 2011; Kimonis et al., 2010; Salerno et al., 2010). Therefore, understanding mental health care providers' attitudes and opinions about JSO treatment is imperative.

Research indicates that personal characteristics of mental health professionals affect attitudes and opinions of clients, therapeutic relationships, and treatment provision (Fortney & Baker, 2009; Ikomi et al., 2009; Jones, 2013). Several personal characteristics of mental health professionals that affect attitudes about JSO treatment have been investigated, including: (a) their experience, (b) training, (c) personal victimization, and (d) race (Jones, 2013; Jung et al., 2012; Kimonis et al., 2010; Sahlstrom & Jeglic, 2008; Salerno et al., 2010; Sandhu & Rose, 2012). Although studies have examined the impact of the mental health professionals' gender on attitudes and treatment, the research has been inconclusive (Church et al., 2008; Jones, 2013). Therefore, understanding how gender influences a provider's beliefs about JSO treatment is essential to ensure that treatment is efficacious and ethical. In addition, research has

not investigated how mental health professionals' religiosity affects their opinions about JSO treatment. Because research has demonstrated that mental health professionals' religiosity is linked to treatment and attitudes in other therapeutic scenarios (Balkin et al., 2009; Bidell, 2014; Kellems et al., 2010), it is imperative to examine how this variable is related with beliefs about JSO treatment. Gender may moderate the relationship between religiosity and attitudes. Limited research has demonstrated that compared to female therapists and "less religious" male therapists, male therapists who described themselves as "more religious" rated clients who engaged in unconventional sexual behaviors as pathological (Hecker, Trepper, Wetcher & Fontaine (1995). More religious male and female therapists were also more likely to diagnose clients with addictions than less religious therapists (Hecker et al., 1995). Because research about the interaction of these variables is non-existent, an analysis of how gender may moderate the relationship between religiosity and attitudes toward JSO treatment can significantly contribute to the existing literature. A deeper understanding of factors that might impact opinions about JSO treatment can improve therapeutic relationships, increase treatment efficacy, and decrease recidivism. Given the lack of research, gender and religiosity of mental health professionals are important factors to examine, and findings can contribute to the existing literature about JSO treatment.

The research design and methodology of this study are presented in Chapter 3. Using this literature review for support, the variables of mental health professionals' gender and religiosity and how they are related to the professionals' attitudes toward JSO

treatment will be examined. In the next chapter I will attempt to fill the gap in the previously described literature.

Chapter 3: Research Method

Introduction

Stereotypical attitudes concerning JSOs include the belief that they cannot be rehabilitated and that they are likely to recidivate (Stevenson et al., 2011; Worling, 2013; Yoder, 2014). Most people label this population as deviant and incapable of changing with treatment (Linn et al., 2010; Mingus & Burchfield, 2012; Wakefield, 2006). Because mental health professionals provide treatment to JSOs and treatment effectiveness relies on positive therapeutic relationships and treatment approaches (Nelson, 2007; Sahlstrom & Jeglic, 2008; Salerno et al., 2010), it is imperative to examine their attitudes about JSO treatment and the labels they use for JSOs themselves. Past research has analyzed how some personal variables of mental health professionals are related to their attitudes toward JSO treatment (Carone & LaFleur, 2000; Jones, 2013; Nelson et al., 2002). However, the relationship between the variable of the mental health professionals' gender and their attitudes toward JSO treatment is limited and inconclusive (Jones, 2013). Additionally, previous scholars have not explored the relationship between the variable of mental health professionals' religiosity and their attitudes toward JSOs. The purpose of this correlational survey study was to examine the relationship between mental health care professionals' religiosity and their attitudes toward JSO treatment. It also examined the relationship between mental health care professionals' gender and their attitudes toward JSO treatment. Additionally, the study explored how gender moderates the relationship between mental health professionals' religiosity and their attitudes toward treatment.

Chapter 3 describes the research design and examines the rationale for the design. The target population, sampling method and procedures, recruitment strategies, and data collection are also discussed. In this chapter, I address the validity and reliability of the ATTSO survey and the SCSRFQ, and it describe the populations in which these instruments have been used. I conclude the chapter with an analysis of ethical procedures and possible threats to validity.

Research Design and Rationale

This study examined if a relationship exists between mental health professionals' gender and religiosity and their attitudes toward JSO treatment. The researcher analyzed how gender moderates the relationship between mental health professionals' religiosity and their attitudes toward JSO treatment. Because these research questions looked for relationships, the nature of this study was a quantitative regression analysis and survey study that was conducted via the Internet. The variables that were examined included mental health professionals' religiosity, mental health professionals' gender, and their attitudes toward JSO treatment. Creswell (2014) states that survey instruments are consistent with quantitative approaches and can produce more objective findings than other methods of acquiring individuals' thoughts or opinions (e.g. interviews). Surveys have been effectively used to quantitatively assess relationships between individuals' attitudes or beliefs and a particular issue (Cengage, 2005). According to Ahern (2005), survey methods also increase the probability that participants will honestly answer questions about sensitive topics, such as sexual offending behaviors. The proposed research questions sought to understand the relationship between mental

health care professionals' religiosity and their attitudes toward JSOs and the relationship between mental health professionals' gender their attitudes toward JSOs. Therefore, surveying mental health care workers attitudes toward JSOs is consistent with quantitative approaches (Frankfort-Nachmias & Nachmias, 2008), and survey methods have been consistently used in multiple research studies to assess professionals' attitudes, beliefs, and treatment approaches (Ferguson & Ireland, 2006; Jones, 2013; Kimonis, et al., 2011; Mann & Barnett, 2013). Findings from this study can provide a basis from which to analyze how the variables of mental health care professionals' gender and spiritual/religious background/beliefs are related to the variable of their attitudes toward adolescent sex offenders.

Methodology

Population/Sampling/Recruitment/Participation

Because the study focused on the attitudes of mental health professionals, the sampling strategy was purposive. Participants for this study included counselors/therapists, school psychologists, psychologists, psychiatrists, social workers, and behavioral health providers. Although the researcher used the Walden participant pool, Google-search, and LinkedIn, many of the participants were contacted through the Arizona Psychological Association. The researcher contacted the following licensing boards from Arizona to obtain permission to notify the mental health members of the online survey study: The Arizona Board of Behavioral Health (for licensed counselors/therapists and behavioral health providers), the Arizona Psychological Association (for licensed psychologists), Arizona Psychiatric Society (for licensed

psychiatrists), Arizona Association of School Psychologists (for school psychologists), and the National Association of Social Workers, Arizona Chapter (for social workers). Because agencies did not permit notification to members on their websites, and listserves did not provide member email addresses, the researcher did not use these associations to contact participants. However, the researcher used her student membership of the Arizona Psychological Association to access email addresses of members. In addition, a Google-search and Linked-In were used to contact other mental health professionals. The Walden participant pool was also used. Survey Monkey Audience was not used. All potential participants received an email that stated the researcher's name and institution, described the purpose and nature of the study, and clarified that participants must be at least 18 years old and that current practice in the mental health field was mandatory for eligibility. No participants were contacted/recruited until IRB permission was received.

Interested and eligible participants were directed to an Internet link. The Internet link stated the researcher's name and that the researcher was a doctoral student with Walden University. Participants were also presented information about: (a) the right to decline participation at any time, (b) anonymity, (c) study description and purpose, (d) possibility of emotional discomfort, (e) probable amount of time for completion, (f) detailed directions, (g) how privacy would be maintained, and (h) the researcher's contact email for any questions about the study. Participants were informed about how surveys were downloaded, that IP addresses would be disabled, and that each survey would be assigned a participant number to maintain anonymity. For questions about rights as participants, contact information of a Walden University representative was provided.

The link also included a consent form which participants were encouraged to copy. Participants were informed that they would not receive any compensation for their participation. They were not allowed to enter the survey until they consented to participate. Gender, type of profession, race, level of training/education, and years of experience were requested through a demographic questionnaire included in the survey. Participants were also asked to complete the ATTSO and SCSRFQ surveys. Once surveys were complete, participants were presented with a debriefing form thanking them for their participation, ensuring their confidentiality, and suggesting that they contact a local mental health professional if they experienced any stress or emotional pain from the survey. Participants were also informed that they have the right to request the results of the study, but that there would be no follow-up emails (with the exception of three reminder emails). Because the survey was anonymous, one follow-up email was sent to participants inviting them to participate in the survey. The follow-up emails were altered to include a thank you statement to those who have already participated. The researcher used all complete surveys.

The subjects submitted their surveys electronically, through a secure server through Survey Monkey. Survey Monkey provided the researcher the option of making the survey anonymous and disabling IP addresses of participants. These options were selected to ensure anonymity, and each completed survey was assigned a participant number. Survey Monkey states that survey data are encrypted and stored in two different servers and monitored for 24 hours every day (Survey Monkey, 2015). Access to the data required a specific username and password created by the researcher. Once all

surveys were completed and data were gathered, Survey Monkey provided multiple options for the data to be transported. The researcher downloaded the surveys/data from the server and stored the data in a password-protected computer. The data were then downloaded into SPSS and were available to the researcher and a statistician. Although the participants were anonymous, the statistician was required to sign a confidentially agreement in accordance with IRB requirements. All data will be stored for five years in the password-protected computer.

Sample Size/Power Analysis

According to Buchner, Faul, and Erdfelder (n.d.), using G*Power analysis to determine sample size requires the researcher to select the type of test, the type of power analysis, the effect size, the alpha level (α) and the power (1- β), and number of variables. The researcher conducted a hierarchical multiple regression to analyze all three research questions and corresponding hypotheses. For a hierarchical regression analysis, Cohen (1988) recommends a medium effect size of .15. Setting alpha at .05 and power at .80 are acceptable levels according to Field (2013). The total number of variables equaled six and included: racial identity, level of training/education, type of profession, years of experience, religiosity, and gender. Using these parameters, G*Power indicated that the number of participants required would be 68. However, the researcher sought 75 participants to safeguard against potential data quality issues.

ATTSO

The ATTSO is a measure developed by Wnuk et al. (2006). Because public opinion often shapes policy and treatment, Wnuk et al. (2006) created the ATTSO to

assess these opinions. After designing the measure with 35 items, the authors administrated the ATTSO to undergraduate psychology students (Wnuk et al., 2006). Choices for ATTSO items are rated on a five-point scale, including: (1)"Disagree Strongly," (2)"Disagree," (3)"Undecided," (4)"Agree," and (5)"Agree Strongly" (Wnuk et al., 2006). Total scores for the ATTSO range from 35-175, with higher scores indicating more negative views of treatment and lower scores indicating more positive views (Wnuk et al., 2006). Positive examples from the ATTSO include: "I believe sex offenders can be treated"; and "Sex offenders can be helped using the proper techniques". Negative examples include: "Sex offenders don't deserve another chance"; and "Sex offenders should be executed" (Wnuk et al., 2006).

Wnuk et al. (2006) conducted an exploratory factor analysis and discovered that fifteen items "statistically and theoretically functioned well, forming three internally consistent factors" (p. 41). The final definitions of the factors were determined by a consensus of experts after they were independently reviewed and named (Wnuk et al., 2006). Factor I was named Incapacitation and comprised eight items; Factor II was named Treatment Ineffectiveness and comprised four items; and Factor III was named Mandated Treatment and comprised three items (Wnuk et al., 2006). "The correlation between *Factor I* and *Factors II and III* was 0.67 and - 0.01, respectively, and the correlation between *Factor II* and *III* was - 0.07. Thus, there was a sizeable correlation between *Factors I* and *II*, and these factors were very weakly associated with *Factor III,*" (Wnuk et al., 2006, p.40). Wnuk et al (2006) incorporate all three factors in the ATTSO scale, and combine them to produce a composite score. Although researchers can

analyze the factors separately, only the composite scores were evaluated in this study.

Wnuk et al. (2006) evaluated internal consistency using Cronbach's alpha coefficients. Cronbach's alpha coefficient for the 15 items was 0.86, and the three factors revealed Cronbach's alpha coefficients of 0.88, 0.81, and 0.78 (Wnuk et al., 2006). These values demonstrate strong internal consistency (Wnuk et al., 2006). Later research conducted by Church, Sun and Li (2011) revealed a Cronbach's alpha of 0.85 for Incapacitation, 0.82 for Treatment Ineffectiveness, and .68 for Mandated Treatment. Wnuk et al. (2006) state that the population sample used for the original study was restricted to college students; therefore, generalizability is limited. The authors state that studies using other populations are necessary for further validation. Future research is also necessary to establish predictability and test-re-test reliability (Wnuk et al., 2006).

Because sex offender treatment is impacted by the attitudes of those providing treatment (mental health professionals), the ATTSO could be used as a screening tool to ensure that those providing treatment believe in its effectiveness (Church et al., 2011; Wnuk et al., 2006). I was unable to find any additional research for validation of the psychometric properties of the ATTSO. This limitation is identified as one of the threats to validity and discussed in the findings.

Although the ATTSO was not standardized on attitudes toward juvenile sex offenders, Sahlstrom and Jeglic (2008) used the ATTSO to examine 208 undergraduate college students' attitudes toward treatment of juvenile sex offenders. Romero (2014) also used the ATTSO to examine the relationship between: (a) years of experience, (b) compassion fatigue, (c) type of risk assessment training, and (d) type of professional

status (therapists and probation officers) and attitudes toward the treatment of juvenile sex offenders. In addition, Dr. Jeglic indicated through email correspondence that applying the ATTSO to juvenile sex offenders should not compromise the psychometric properties of the instrument (E. Jeglic, Personal Communication, March 2015). Therefore, I directed the participants to complete the survey for attitudes toward juvenile sex offenders. Permission to use the ATTSO online was obtained through email correspondence from Dr. Elizabeth Jeglic.

SCSRFQ

The SCSRFQ is a ten-item measure that assesses an individual's religious faith using a four point Likert scale ranging from "1 = strongly disagree" to "4 = strongly agree" (Plante & Boccaccini, 1997). The sum of the ten items produces total scores ranging from 10 (low faith) to 40 (high faith) (Plante & Boccaccini, 1997). Spanish, Portuguese, Chinese, and German versions of the SCSRFQ are available (Plante & Boccaccini, 1997), as well as an abbreviated version called the Abbreviated Santa Clara Strength of Religious Faith Questionnaire (Plante, Vallaeys, Sherman, & Wallston, 2002). The questionnaire does not assume that the participant espouses any religion (Plante et al., 2002), and it can be used among a variety of denominations (Freiheit, Sonstegard, Schmitt, & Vye, 2006). Example statements from the SCSRFQ include: "My religious faith is extremely important to me", "I look to my faith as a source of comfort", and "My faith impacts many of my decisions (Plante & Boccaccini, 1997a). Sherman et al. (2001), state that the measure has high test-retest reliability (*r*s = .82 -.93), and Plante and Boccaccini, (1997a, 1997b) indicate the SCRSFQ exhibits high internal

consistency reliability coefficients (Cronbach's alpha = .94-.97) and split-half reliability (r = .92). Convergent validity of the SCSRFQ is also high when compared to other measures of religiosity (Sherman et al., 2001). The SCSRFQ has been used in research studies with high school, college, and adult participant populations (Cummings et al., 2015; Plante & Boccaccini, 1997b). In addition, the SCSRFQ was used in a study of cancer patients (Sherman et al., 2001), gay, lesbian, and bisexual participants (Lease, Horne, Noffsinger-Frazier, 2005), and substance dependent individuals (Plante, Yancey, Sherman, Guertin, & Pardini, 1999). The researcher obtained permission to use the SCSRFQ online from one of the authors, Dr. Thomas Plante, through email correspondence.

Data Analysis

All data were downloaded from the secure server onto a password-protected computer so that analyses could be conducted using SPSS. A hierarchical regression analysis with three models was conducted to evaluate the research questions and hypotheses. Using Model 1 allowed me understand how the confounding variables of race, type of profession, level of training/education, and years of experience influenced the results. Effects of these confounding variables are described, including estimates of effect and their confidence intervals. These are reported in Chapter 4, and the implication of these confounding variables is discussed in Chapter 5. Model 2 was used to analyze the main effects of gender and religiosity on attitudes toward JSO treatment, and I used Model 3 to obtain data about the interaction of gender and religiosity to evaluate moderation.

Research Questions and Hypotheses. RQ 1: Is there a relationship between the religiosity of mental health professionals and their attitudes toward JSO treatment?

H_0: There is no relationship between mental health care professionals' spiritual/religious background/beliefs and their attitudes toward JSO treatment.

H_1: There is a relationship between mental health care professionals' religiosity and their attitudes toward JSO treatment.

RQ2: Is there a relationship between gender of mental health care professionals and their attitudes toward JSO treatment?

H_0: There is no relationship between the gender of mental health care professionals' and their attitudes toward JSO treatment.

H_1: There is a relationship between the gender of mental health care professionals' and their attitudes toward JSO treatment.

RQ3: Is the relationship between religiosity and attitudes toward JSO treatment moderated by gender?

H_0: The relationship between religiosity and attitudes toward JSO treatment is not modified by gender.

H_1: The relationship between religiosity and attitudes toward JSO treatment is modified by gender.

Ensuring Accuracy of Data Collection

In the proposal, I planned for the following: (a) an equation would be entered into SPSS to eliminate entire participant data sets where participants failed to complete 80% of each survey – (28 items for the ATTSO and 8 items for the SCSRFQ); (b) mean scores

for each participant would be computed for the survey(s) and substituted for missing items for those data sets that were retained with missing survey items; (c) and data sets for participants who failed to answer two or more items on the demographic form would not be used. However, because I was able to obtain 123 complete data sets, the plans for incomplete data sets were not used. Additionally, I originally proposed that the survey would include a question about whether the participant had already completed the survey. However, I did not need to determine which surveys were duplicates because the survey was designed to not allow duplicate IP addresses to complete the survey. As described below, I planned to transform data sets that did not fit the assumptions necessary for a hierarchical multiple regression analysis. However, all data sets fit the assumptions and were used in the analyses.

Hierarchical Multiple Regression. I conducted a hierarchical multiple regression to examine all three research questions and corresponding hypotheses. Using hierarchical multiple regression, I entered the variables, or sets of variables, in a fixed, sequential order into a regression equation. This provided control for confounding variables, and it promoted my understanding of how each variable added to the prediction of the dependent variable. I entered the demographic variables (confounding variables) first into the regression equation (model 1) to account for their effects on attitudes toward JSO treatment. Then two separate regressions were conducted with the variables gender and religiosity (model 2) to evaluate each of their main effects on attitudes toward JSO treatment. Finally, I entered the interaction of gender and religiosity (model 3). This third model allowed me to assess moderation of the variable gender on religiosity and

attitudes toward JSO treatment.

In order to conduct a hierarchical regression analysis the following assumptions must be met: (a) there must be independent observations, (b) a linear relationship must exist, (c) homoscedasticity of residuals, (d) no multicollinearity, (e) no significant outliers, (f) no significant leverage points or influential cases, and a (g) normal distribution of residuals. The Durbin-Watson statistic was used to evaluate independent observations. The statistic demonstrated that there were no correlated errors, so there was independence of observations. A grouped scatterplot was performed to determine if a linear relationship existed. The scatterplot confirmed linearity. I proposed the following steps if a linear relationship did not exist: (a) I would transform the variables using a "square root" transformation for moderately, positively skewed data and a "reflect and square root" transformation for moderately, negatively skewed data; (b) for more extremely, positively skewed data, I would use an "inverse" transformation; (c) for more extremely, negatively skewed data, I would use a "reflect and inverse" transformation; and (d) the scatterplot would be re-run to determine if a linear relationship existed. A grouped scatterplot was used to determine homoscedasticity. Analysis of the scatterplot confirmed this assumption was met. If this assumption had been violated, I planned to transform the variables using a logarithmic transformation. I examined the tolerance and variance inflation factor (VIF) statistics to determine multicollinearity. Examination of these statistics confirmed there was no multicollinearity. If multicollinearity problems were discovered, I would mean center the independent variable to reduce multicollinearity and re-run the test. Outliers were

addressed with the correlational analyses. Leverage points and influential points were examined with the regression. I selected the "leverage value" box in SPSS to determine if any cases had a leverage value greater than 0.2. Cases with leverage values greater than 0.2 were recorded, and I examined how these cases could lead to high influence. "Cook's" option was also selected and evaluated to examine influential points among cases. Cases with values above "1" would be recorded. However, I did not need to transform or remove any cases. Examination of the histogram and the Shapiro -Wilk statistic allowed me to determine normality. If normality was violated, I proposed to try to transform the variables. I reported: (a) means, (b) standard deviations, (c) sample size, (d) significance values, (e) degrees of freedom, (f) confidence intervals, (g) standard error of the coefficients ($SE\,\beta$), (h) unstandardized coefficients (B), (i) standardized coefficients (β), (j) R^2 statistic, (k) sum of squares, and (l) F values.

Threats to Validity

Threats to External Validity

Although most participants were contacted through the Walden participant pool, Google searches, and LinkedIn, many participants were contacted through the researcher's Arizona Psychological Association member email list. Therefore, the findings may not be generalizable to mental health professionals in other states or globally. I addressed this threat in the discussion of possible limitations.

Threats to Internal Validity

Social desirability bias is a potential threat with self-report measures, such as surveys. Participants may have felt pressured to answer the survey questions in the most

socially acceptable manner (Krumpal, 2013). Surveys that examine socially or personally sensitive issues, such as illegal behaviors, racism, or sexual behaviors, can be some of the most difficult to answer truthfully (Krumpal, 2013). Therefore, social desirability bias could have been problematic because the focus of this study is attitudes toward sexual offending behaviors and treatment. However, Ahern (2005) indicates that anonymous surveys can decrease social desirability bias (Ahern, 2005).

Because the survey was completed on the Internet, I was not able to control the testing environment, data privacy, or who completed the survey (Ahern, 2005). I only sent the survey invitation and link to mental health professionals, but other individuals may have completed the survey in place of the contacted participant. Inaccurate reporting may have occurred if the participant completed the survey in an environment that was distracting or felt exposed to public scrutiny. I established steps to ensure participants' privacy and anonymity in the study, but participants might not have taken proactive steps to protect their privacy while completing the surveys. For example, participants may have completed the survey in a public location where other individuals could have seen their answers. All limitations are discussed in Chapter 5.

Although this study focused on the variables of gender, religiosity, and attitudes toward treatment, the confounding variables from the demographic questionnaire were analyzed to determine if they affected the regression analyses. The results could have been impacted by other personal characteristics that were not included in the demographic questionnaire. The potential effect of these unidentified variables is addressed in the limitations section of Chapter 5.

Construct and Statistical Conclusion Validity

Construct validity of the ATTSO could be problematic due to the weak associations between factors, a few low Cronbach's alpha coefficients of internal consistency (Church et al., 2011), and a limited amount of outside research validating the psychometric properties. I relied on the reported validity and reliability of ATTSO and SCSFRQ, but errors in the reported validity/reliability of these instruments could influence findings. These potential threats to validity are discussed among the findings.

Conclusion validity may have occurred if I drew the wrong conclusion about the relationship between mental health professionals' gender and attitudes toward JSOs and/or the relationship between mental health professionals' religiosity and attitudes toward JSOs. Good statistical power and increased effect size can improve my understanding of the statistical significance of the results, thus decreasing errors of conclusion (Field, 2013).

Ethical Procedures

Before contacting potential participant groups, IRB approval was obtained. The approval number for this study was 08-24-15-0315521. Once IRB approval was provided, I contacted the following licensing boards from Arizona to obtain permission to notify members of the online survey study: (a) The Arizona Board of Behavioral Health (for licensed counselors/therapists and behavioral health providers), (b) the Arizona Psychological Association (for licensed psychologists), (c) Arizona Psychiatric Society (for licensed psychiatrists), (d) Arizona Association of School Psychologists (for school psychologists), and (e) the National Association of Social Workers, Arizona Chapter (for

social workers). I requested IRB permission to purchase/request listserves to contact members of these agencies in case these agencies would not allow me to recruit through their websites. Because I am a student member of the Arizona Psychological Association, I accessed members' email addresses through the "members listed" webpages. In addition, I used Google searches, LinkedIn, and the Walden participant pool to contact other mental health professionals. Therefore, I obtained permission from Walden University IRB to also utilize the Arizona Psychological Association member list, Google, LinkedIn, and the University's participant pool to contact participants.

I obtained Walden University's IRB approval prior to participant recruitment and survey administration. Participants were limited to individuals who were at least 18 years old and practicing in the mental health field. These limitations were reasonable to protect vulnerable individuals (younger than 18) and because the focus of the study is about characteristics of mental health professionals. Support for the exclusion criteria was provided in the notification to potential participants, which also included a description of the study and its potential benefits to the mental health field. Prior to entering the survey, participants were informed that they had the right to decline participation or discontinue the survey at any time. Although I did not believe any potential adverse events related to the survey would occur, participants were encouraged to seek professional help if any part of the survey led to emotional distress.

No personal identifying information was requested in the survey, making it anonymous. In addition, IP addresses were disabled when the surveys were downloaded to Survey Monkey. I implemented a username and password for data access through

Survey Monkey, and sites that store Survey Monkey data are monitored continuously. Data were downloaded and stored on a computer with password protection. The statistician and me were the only individuals to access the data. Data will be destroyed after five years.

Summary

To examine the relationship between mental health care professionals' religiosity and their attitudes toward JSOs and the relationship between mental health care professionals' gender and their attitudes toward JSOs, the research design was a quantitative correlational approach using Internet surveys. Using a purposive sampling strategy, I limited participants to those practicing in the mental health field. Results from a power analysis revealed that 68 participants were needed. Following IRB approval, participants were recruited through the Arizona Psychological Association, LinkedIn, Google search, and the Walden participant pool. Each eligible participant was directed to an Internet link that stated my name and institution, the purpose of the study, and how participant anonymity would be maintained. This portion of the link also discussed the participant's right to decline or discontinue the survey, and it required consent to participate. Once participants provided consent, they entered the survey. The survey included a demographic questionnaire that asked participants to indicate gender, type of profession, race, and years of experience. Participants were also asked to complete the SCSRFQ and the ATTSO. Completed surveys were directly downloaded to a secure server (Survey Monkey), and IP addresses were disabled. From Survey Monkey, data was downloaded into SPSS on a password-protected computer. A hierarchical multiple

regression analysis was conducted to address the research questions and hypotheses. To account for their effects on attitudes toward JSO treatment, I included type of profession, race, and years of experience in the initial model (model 1). Model 2 included the variables gender and religiosity to evaluate their main effects on attitudes toward JSO treatment. Finally, the interaction of gender and religiosity was entered into model 3 to allow me to assess moderation of the variables gender and religiosity. For the hierarchical multiple regression analysis, I selected the following parameters: (a) effect size at 0.15, (b) alpha at 0.05, and (c) power at 0.80. Threats to validity are addressed in the findings. Data will be stored for five years.

In Chapter 4, I discuss the length of time needed for data collection and any discrepancies in data collection from those stated in Chapter 3. Findings from the hierarchical multiple regression analyses are revealed. I examine statistical assumptions, research questions, and hypotheses in Chapter 4. Descriptive statistics, tables, and graphs are also provided. Finally, I summarize answers to the research questions and hypotheses.

Chapter 4: Results

Introduction

The purpose of this quantitative survey study was to examine the relationship between mental health care professionals' religiosity and gender and their attitudes toward JSO treatment. The study also explored how gender moderates the relationship between mental health professionals' religiosity and their attitudes toward treatment. The study was designed to answer three research questions and corresponding hypotheses.

Research Questions

RQ 1: Is there a relationship between the religiosity of mental health professionals and their attitudes toward JSO treatment?

H_0: There is no relationship between mental health care professionals' spiritual/religious background/beliefs and their attitudes toward JSO treatment.

H_1: There is a relationship between mental health care professionals' religiosity and their attitudes toward JSO treatment.

RQ2: Is there a relationship between gender of mental health care professionals and their attitudes toward JSO treatment?

H_0: There is no relationship between the gender of mental health care professionals' and their attitudes toward JSO treatment.

H_1: There is a relationship between the gender of mental health care professionals' and their attitudes toward JSO treatment.

RQ3: Is the relationship between religiosity and attitudes toward JSO treatment moderated by gender?

H_0: The relationship between religiosity and attitudes toward JSO treatment is not moderated by gender.

H_1: The relationship between religiosity and attitudes toward JSO treatment is moderated by gender.

To answer the research questions and hypotheses, the researcher performed a hierarchical regression analysis. This chapter describes the participant sample, data collection, design procedures, and results of the analyses.

Data Collection

I contacted the participants for this study using a purposive sampling strategy. Following IRB approval, the researcher contacted the following licensing boards from Arizona to obtain permission to notify members of the online study: The Arizona Board of Behavioral Health, the Arizona Psychological Association, Arizona Psychiatric Society, Arizona Association of School Psychologists, and the National Association of Social Workers, Arizona Chapter. The Arizona Board of Behavioral Health, The Arizona Psychological Association, and the Arizona Chapter of the National Association of Social Workers did not permit me to notify their members, and I declined to purchase listserves because they did not include email addresses. The Arizona Association of School Psychologists and the Arizona Psychiatric Society never contacted the researcher, despite attempts to receive permission to contact members. I used my student membership in the Arizona Psychological Association to access email addresses of members. In addition, a Google search and LinkedIn were used to contact other mental health professionals. The Walden participant pool was also used to contact students who were currently practicing

in the mental health field. An initial email was sent on September 29, 2015 to members of the Arizona Psychological Association, mental health professionals identified through Google search, and LinkedIn contacts that currently worked in mental health professions. The email was also posted in mental health groups to which the researcher belonged in LinkedIn. Walden participant pool members did not receive this email because the researcher did not receive approval to directly contact eligible participants. The email and the study posted in the Walden participant pool provided a link to the survey, which was stored in Survey Monkey. On October 6, 2015, a follow-up reminder email was sent only to individuals identified through the Google search.

Response Rates

Data collection began on September 29, 2015 and ended on October 17, 2015. A total of 148 participants responded to the survey. However, only 123 individuals completed the entire questionnaire (all demographic information, all SCSRFQ questions, and all ATTSO questions). The researcher used the 123 completed surveys for analysis, deleting 25 cases.

Characteristics of the Sample

A summary of the sample's (N = 123) demographic characteristics is provided in Table 1. More men (60.2%) than women (39.8%) responded to the study. The majority of survey respondents were Caucasian (89.4%). Hispanic/Latinos (6.5%) were the second largest racial category of participants. Asians (2.4%) and African Americans (1.6%) comprised the rest of the population. None of the respondents indicated that they were Alaska Native or American Indian, Native Hawaiian/Pacific Islander, or Other.

Master's degrees were held by 48% of the participants. 46.3% of the respondents had doctoral degrees, and 5.7% had bachelor degrees. The majority of participants reported being psychologists (43.1%). Counselor/therapists represented the second largest group of participants (34.2%). The sample also consisted of school psychologists (8.1%), social workers (5.7%), behavioral health workers (4.1%), and one psychiatrist (0.8%). Finally, 4.1% of respondents indicated that they were trained in a field other than psychology, social work, counseling, school psychology, psychiatry, or behavioral health.

The largest number of participants indicated they had twenty or more years of experience (31.7%). Participants with 10-20 and 6-10 years of experience each represented 21.1% of the sample. Those with 3-5 years of experience represented 15.5% of total participants. The smallest percentage of the sample (10.6%) consisted of individuals with 1-2 years of experience.

The largest number of participants were recruited through email (50.41%). Individuals recruited through LinkedIn represented 45.53% of the participant sample. Finally, 4.07% of participants were recruited through the Walden participant pool.

There were no data available to compare the representation of the sample to the population of interest.

Table 1

Descriptive Statistics of Demographic Variables

Variable	*N*	Category	Frequency	Percent
Gender	123	Female	74	60.2
		Male	49	39.8
Race	123	Asian	3	2.4
		Black	2	1.6
		Caucasian	110	89.4
		Hispanic/Latino	8	6.5
		Alaska Native or American Indian	0	0
		Native Hawaiian /Pacific Islander	0	0
		Other	0	0
Training/Education	123	Bachelor's degree	7	5.7
		Master's degree	59	48
		Doctoral degree	57	46.3
Type of profession	123	Psychologist	53	43.1
		Social Worker	7	5.7
		School Psychologist	10	8.1
		Counselor/Therapist	42	34.2
		Psychiatrist	1	0.8
		Behavioral Health Provider	5	4.1
		Other	5	4.1
Years of Experience	123	1-2	13	10.6
		3-5	19	15.5
		6-10	26	21.1
		10-20	26	21.1
		20+	39	31.7

Assumptions Tested for Hierarchical Regression

The assumption of independence of observations was met, as assessed by the Durbin-Watson statistic of 2.178, which is acceptable. Examination of scatterplots revealed that the linearity and homoscedasticity assumptions were not violated, so

transformation of data was not necessary. VIF and tolerance values revealed there was not a problem of collinearity in the data. Examination of the scatterplots confirmed there were no significant outliers. Influential points and leverage points were also examined. Cook's distance values for the data were less than the critical value of 1, indicating there were no influential cases. However, 19 cases had leverage values greater than 0.2, but they were included in the main analysis because they did not influence the results. The Shapiro-Wilk test of normality statistic of 0.984 ($p > .05$), and the histogram was approximately normal. These demonstrate the distribution of residuals was normal.

Responses to the ATTSO and the SCSRFQ

ATTSO. The ATTSO scale is composed of 35 items and has three factors. In addition to the total (composite) score, the ATTSO factors can be scored separately. However, the researcher only used total scores for this study. Total scores range from 35-175, with higher scores indicating more negative views of treatment and lower scores indicating more positive views (Wnuk et al., 2006). The ATTSO mean was 82.42 (SD = 11.459), which is slightly lower than the expected mean (M=105). The range of scores for the ATTSO was 54 to 120. These values indicate that participants did not choose the most extreme answers, which would have indicated extreme positive or negative attitudes toward JSO treatment. However, as stated in Chapter 3, little research has been conducted using the ATTSO, so there are few findings to use for comparison. Good reliability of the ATTSO was confirmed by calculating a coefficient alpha for the composite score (0.83), which is considered to demonstrate good internal consistency (Field, 2013). This

score was also similar to the alpha coefficient (0.86) produced by 170 subjects in a study by Wnuk et al. (2006).

Table 2

Descriptive Statistics for the ATTSO

Statistic	Total Score
Valid N	123
Missing	0
Mean	82.42
SD	11.459
Minimum	54
Maximum	120
Coef. α	0.83

Standardized skewness and standardized kurtosis were examined for the ATTSO to assess the degree of normal distribution. Standardized skewness value was 2.303 (*SE* = .218), and standardized kurtosis value was 2.332 (*SE* = .433), indicating a normality of the distribution for the ATTSO.

SCSRFQ. The SCSRFQ is a ten-item measure, and the sum of the ten items produces total scores ranging from 10 (low faith) to 40 (high faith) (Plante & Boccaccini, 1997). The SCSRFQ mean was 24.92 (SD = 10.263). The range of scores for the SCSRFQ was 10 to 40, which perfectly fits the theoretical range (10-40) described by Plante and Boccaccini (1997). These findings are also similar to the previous range of scores of 11-40 in a study by Sherman et al. (1999). Plante and Boccaccini (1997a, 1997b) reported high internal consistency reliability coefficients (Cronbach's alpha = .94

- .97). Good reliability of the SCSRFQ was confirmed by calculating a coefficient alpha for the total score (0.98).

Table 3

Descriptive Statistics for the SCSRFQ

Statistic	Total Score
Valid N	123
Missing	0
Mean	24.92
SD	10.263
Minimum	10
Maximum	40
Coef. α	0.98

Skewness and kurtosis were examined for the SCSRFQ to assess the degree of normal distribution. The standardized skewness value was 0.101 (*SE* = .218), demonstrating there is no significant violation of symmetry in the variable distribution. The standardized kurtosis value was -2.808 (*SE* = .433), indicating a higher degree of peakedness on the extremes for the SCSRFQ.

Data Analysis Results

Research Question 1

The first research question was designed to examine the relationship between the religiosity of mental health professionals and their attitudes toward JSO treatment. First, the hypotheses were tested examining Pearson's r coefficient of correlation. There was no statistically significant correlation between religiosity and attitudes toward JSO treatment (r = -.100, p = .269).

Table 4

ANOVA Table for Hierarchical Regression Analysis with Santa Clara Strength of Religious Faith Questionnaire (N=123)

Model	Sum of Squares	*df*	Mean Square	*F*	Sig.
Regression	3144.800	12	262.067	2.239	.014*
Residual	12875.216	110	117.047		
Total	16020.016	122			

$p < .05$

Hierarchical multiple regression was also used to test the hypotheses from research question 1. After controlling for race, training, type of profession, and years of experience, the total ATTSO score was used as the dependent variable, and the SCSRFQ total was used as the predictor variable in the regression analysis. Initial analysis of the regression model (Table 4) demonstrates significance ($F = 2.239$, $p < .05$). However, closer examination revealed that the addition of SCSRFQ total to the existing variables did not significantly contribute to the prediction of ATTSO total (R^2 change = .003; F change (1, 110) =.356 ; $p = .552$). When controlling for race, training, type of profession, and years of experience, only 0.3% of the variance of attitudes toward JSO treatment was accounted for by religiosity.

Table 5 shows the regression weights that were analyzed for this block model. Religiosity (SCSRFQ) did not have a significant relationship to attitudes toward JSO treatment ($B = -.063$, $p = .552$).

Table 5

Regression Coefficients for Santa Clara Strength of Religious Faith Questionnaire (N=123)

Model		Unstandardized Coefficients		Standardized Coefficients	*t*	Sig.
		B	*SE B*	*B*		
	Constant	99.284	5.581		17.788	<.001
2	SCSRFQ	-.063	.106	-.057	-.597	.552

$p < .05$, $N = 123$

The Pearson's *r* coefficient of correlation indicated that there was no significant relationship between religiosity and attitudes toward JSO treatment. Additionally, when controlling for demographic variables of race, training, type of profession, and years of experience, religiosity did not account for any statistically significant variance of attitudes toward JSO treatment. Because there was a lack of sufficient evidence to support a relationship between mental health care professionals' religiosity and their attitudes toward JSO treatment, the null hypothesis cannot be rejected.

Research Question 2

The second research question was designed to examine the relationship between the gender of mental health care professionals and their attitudes toward JSO treatment. First, the hypotheses were tested examining Pearson's *r*. There was no statistically significant correlation between gender and attitudes toward JSO treatment, $r = -.093$, $p = .308$

Table 6

ANOVA Table for Hierarchical Regression Analysis with Gender (N=123)

Model	Sum of Squares	*df*	Mean Square	*F*	Sig.
Regression	3248.889	12	270.741	2.332	.011*
Residual	12771.127	110	116.101		
Total	16020.016	122			

$p < .05$

Hierarchical multiple regression was also used to test the hypotheses from research question 2. After controlling for race, training, type of profession, and years of experience, the total ATTSO score was used as the dependent variable, and gender was used as the predictor variable. Initial analysis of the regression model (Table 6) demonstrates significance ($F = 2.332$, $p < .05$). However, closer examination revealed that the addition of gender to the existing variables did not significantly contribute to the prediction of ATTSO total (R^2 change = .009; F change (1, 110) =1.256; $p = .265$). When controlling for race, training, type of profession, and years of experience, only 0.9 % of the variance of attitudes toward JSO treatment was accounted for by gender.

Table 7 shows the regression weights that were analyzed for this block model. Gender did not have a significant impact on attitudes toward JSO treatment ($B = -2.464$, $p = .265$).

Table 7

Regression Coefficients for Gender (N=123)

Model		Unstandardized Coefficients		Standardized Coefficients	*t*	Sig.
		B	*SE B*	*B*		
	Constant	98.429	5.238		18.793	<.001
2	Gender	-2.464	2.199	-.106	-1.121	.265

$p < .05$, $N = 123$

The Pearson's *r* correlational analyses indicated that there was no significant relationship between gender and attitudes toward JSO treatment. Additionally, when controlling for demographic variables of race, training, type of profession, and years of experience, gender did not account for any statistically significant variance of attitudes toward JSO treatment. Therefore, the null hypothesis for the second research question, "There is no relationship between mental health care professionals' gender and their attitudes toward JSO treatment" cannot be rejected.

Research Question 3

The third research question was designed to examine how religiosity and attitudes toward JSO treatment were moderated by gender.

Table 8

ANOVA Table for Hierarchical Regression Analysis with Interaction of Gender and Religiosity (N=123)

Model	Sum of Squares	*df*	Mean Square	*F*	Sig.
Regression	3295.608	14	235.401	1.998	.024
Residual	12724.409	108	117.819		
Total	16020.016	122			

$p < .05$

Hierarchical multiple regression was used to test the hypotheses from research question 3. After controlling for race, training, type of profession, years of experience, religiosity and gender, the total ATTSO score was used as the dependent variable, and the interaction of gender and religiosity was the predictor variable. Initial analysis of the regression model (Table 8) demonstrates significance ($F = 1.988$, $p < .05$). However, closer examination revealed that the addition of the interaction of gender and religiosity to the existing variables did not significantly contribute to the prediction of ATTSO total ($R^2 = .000$, F change $(1,108) = .023$, $p = .879$). When controlling for race, training, type of profession, years of experience, gender, and religiosity, the interaction of gender and religiosity did not contribute at all to the variables already included.

Table 9 shows the regression weights that were analyzed for model 3. The interaction of gender and religiosity did not have a significant impact on attitudes toward JSO treatment ($B = .030$, $p = .879$).

Table 9

Regression Coefficients for Interaction of Gender and Religiosity (N=123)

Model		Unstandardized Coefficients		Standardized Coefficients	*t*	Sig.
		B	*SE B*	*B*		
	Constant	99.657	5.625		17.717	<.001
3	Gender and Religiosity Interaction	.030	.199	.014	.152	.879

$p < .05$

When controlling for demographic variables of race, training, type of profession, years of experience, gender, and religiosity, the interaction of gender and religiosity did not account for any statistically significant variance of attitudes toward JSO treatment. Therefore, the null hypothesis for the third research question, "The relationship between religiosity and attitudes toward JSO treatment is not moderated by gender" cannot be rejected.

Table 10

Model Summary for Variables Predicting ATTSO (N=123)

Model	*R*	R^2	Adjusted R^2	Standard Error of Estimate	R^2 Change	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.440	.194	.114	10.78742	.194	2.424	11	111	.010*
2	.453	.206	.111	10.80568	.012	.813	2	109	.446
3	.454	.206	.103	10.85443	.000	.023	1	108	.879

a. Predictors: Race, training, type of profession, years of experience
b. Predictors: Race, training, type of profession, years of experience, gender, and SCSRFQ total
c. Predictors: Race, training, type of profession, years of experience, gender, SCSRFQ total, Interaction
Dependent Variable: ATTSO
$p < .05$

Evaluating Model 1

Although the predictors did not lead to statistically significant increases in model 2 and model 3, I examined model 1 because there was a statistically significant change (See Table 10) when the control variables racial identity, training, type of profession, and years of experience were entered into the model (R^2 = .194, F change (11,111) = 2.424, p = .010). Further examination of the coefficients table output of the regression model revealed the predictors of racial identity and type of profession had the significant beta coefficients and contributed statistically significant to the model. Therefore, an analysis of variance was performed to examine how control variables impact attitudes toward JSO treatment.

Descriptive statistics for participants' type of profession are presented in Table 11, and descriptive statistics for participants' racial identity are presented in Table 12.

Table 11

Means and Standard Deviations of Attitude Scores for Type of Profession (N = 123)

			95% Confidence Interval	
Type of Profession	*M*	*SD*	Lower Bound	Upper Bound
Psychologist	83.896	6.51	76.320	91.471
Counselor/Therapist	80.321	8.93	73.935	86.706
School Psychologist	90.024	13.15	82.669	97.379
Social Worker	79.943	11.07	71.086	87.200
Behavioral Health Provider	82.875	6.77	70.959	94.791
Other	106.900	8.39	95.225	118.575

Table 12

Means and Standard Deviations of Attitude Scores for Racial Identity (N = 123)

Racial Identity			95% Confidence Interval	
	M	*SD*	Lower Bound	Upper Bound
Black or African American	87.000	5.66	71.927	102.703
Asian	105.250	17.10	92.197	118.303
White	82.439	11.03	79.297	85.581
Hispanic or Latino	85.278	11.79	77.603	92.952

Prior to examining output of ANOVA, homogeneity of variance was confirmed through Levene's test of equality of error variance ($F(12,110) = .935$, $p > 0.05$).

Table 13

ANOVA Summary for Attitudes by Type of Profession and Racial Identity (N = 123)

Source	SS	df	MS	F	*p*	η^2
Type of Profession	1868.528	5	373.706	3.230	.009*	.128
Racial Identity	1048.372	3	349.457	3.201	.033*	.076
Interaction	453.251	4	113.313	.979	.422	.034
Error	12726.143	110	115.692			

*$p < .05$

Results from the ANOVA revealed that there was a statistically significant main effect of type of profession on attitudes toward JSO treatment, $F(5, 110) = 3.230$, $p < 0.01$, $\eta^2 = 0.128$. These results indicate that type of profession explains 12.8% of the variance in attitudes toward JSO treatment. Post-hoc tests (LSD) revealed statistically significant mean difference between "other" participants' attitudes and all other groups of participants. There was a statistically significant mean difference between "other"

participants' attitudes and psychologists' attitudes (23.004, 95% CI [9.087, 36.922], $p <$ .05). A statistically significant mean difference was found between "other" participants' attitudes and counselors'/therapists' attitudes (mean difference = 26.579, 95% CI [13.272, 39.887], $p <$ .000). The statistically significant mean difference between "other" participants' and school psychologists' attitudes was 16.876, 95% CI [3.078, 30.675], $p <$ .05. A statistically significant mean difference of 27.757, 95% CI [13.572, 41.942], $p <$ .000 was found between "other" participants' attitudes and social workers' attitudes. There was also a statistically significant mean difference between "other" participants' attitudes and behavioral health providers' attitudes of 24.205, 95% CI [7.343, 40.707], $p <$ .05. These findings reveal that "other" participants held statistically significant more negative attitudes toward JSO treatment than psychologists, counselors/therapists, school psychologists, social workers, and behavioral health providers.

Results from the ANOVA demonstrated that racial identity significantly affected attitudes toward JSO treatment, $F(3, 110) = 3.021$, $p < 0.05$, $\eta^2 = 0.076$. These findings indicate that racial identity explains 7.6% of the variance in attitudes toward JSO treatment. Simple pairwise comparisons revealed that ATTSO scores were 87.000 (SD = 5.66) for African American participants, 105.250 (SD = 17.10) for Asian participants, 85.278 (SD = 11.79) for Hispanic/Latino participants, and 82.439 (SD = 11.03) for White participants. There was a statistically significant mean difference between Asian participants' attitudes and Hispanic/Latino participants' attitudes of 19.972, 95% CI [4.830, 35.114], $p <$ .05. There was also a statistically significant mean difference between Asian participant attitudes and White participants' attitudes of 22.811, 95% CI

[9.385, 36.238], $p < .005$. These findings reveal that the Asian participants held more negative attitudes toward JSO treatment than the White participants and Hispanic/Latino participants.

Results from the ANOVA indicated that there was not a statistically significant main effect of the interaction of profession and race on attitudes toward JSO treatment, $F(4, 110) = .979$, $p = .422$, $\eta^2 = 0.034$.

Summary

The findings from the correlational and hierarchical regression analyses reveal that all three null hypotheses should be kept, and the alternative hypothesis should be rejected. Specifically, there were no statistically significant relationships between mental health professionals' religiosity or gender and their attitudes toward JSO treatment, and religiosity and attitudes toward JSO treatment were not statistically moderated by gender. However, examination of model 1 of the hierarchical regression revealed that further analysis of the control variables should be explored because they are associated with attitudes toward JSO treatment. Examination of the ANOVA demonstrated that type of profession and racial identity were significantly related to attitudes toward JSO treatment. I address the findings and conclusions for the study in Chapter 5. Limitations are addressed, and recommendations for future action and further research are provided.

Chapter 5: Discussion, Conclusions, and Recommendations

Purpose

The purpose of this study was to examine the relationship between mental health professionals' religiosity and gender and their attitudes toward JSO treatment. Research has demonstrated mental health providers' negative attitudes toward JSO treatment can decrease treatment effectiveness (Jones, 2013; Nelson, 2007; Wakefield, 2006; Worling & Langton, 2012) and potentially increase recidivism (Chaffin, 2008; Jones, 2013; Kimonis et al., 2010; Worling & Langton, 2012). Previous studies have examined how the provider's training, victimization, experience, and race impact opinions and treatment methods (Jones, 2013; Kimonis et al., 2010; Nelson et al., 2002; Sandhu & Rose, 2012). Additionally, Jones (2013) examined how gender impacted attitudes toward JSOs, but he did not find a statistically significant relationship between gender and attitudes toward JSOs. Research regarding the relationship between mental health professionals' religiosity and perceptions of JSO treatment is nonexistent. Therefore, this study was designed to expand the research about how mental health professionals' personal characteristics relate to their attitudes toward JSO treatment.

Findings revealed there were no significant relationships between mental health professionals' religiosity and their attitudes toward JSO treatment or mental health professionals' gender and their attitudes toward JSO treatment. The relationship between religiosity and attitudes toward JSO treatment was not moderated by gender. However, further analysis revealed that profession type and racial identity did have a statistically significant relationship with attitudes toward JSO treatment.

Interpretation of the Findings

Mental Health Professionals' Religiosity

Although research has demonstrated that mental health professionals' religion is linked to treatment and attitudes in some therapeutic scenarios (Balkin et al., 2009; Bidell, 2014; Kellems et al., 2010), Chapter 2 explained there is no current research about how religiosity impacts their opinions about JSO treatment. Balkin et al. (2009) and Bidell (2014) stated that some mental health professionals who are more fundamental or conservative in their religious beliefs might hold more negative attitudes of individuals engaged in unconventional sexual behaviors. According to labeling theory, such attitudes may lead these professionals to label JSOs as deviant and incapable of change (Becker, 1963). The lack of research about how mental health professionals' religiosity impacts the labeling of JSOs and their attitudes toward JSO treatment justified the investigation of this variable. The findings of this study revealed that there was no statistically significant relationship between mental health professionals' religiosity and their attitudes toward JSO treatment. When controlling for race, training, type of profession, and years of experience, only 0.3% of the variance of attitudes toward JSO treatment was accounted for by religiosity. Because this variable has never been examined, it is difficult to explain the findings. Participants endorsed a full range of scores on the SCSRFQ but did not endorse extreme scores on the ATTSO, which could have impacted the correlation between religiosity and attitudes. The differences between the two distributions of scores could have lowered the maximum value of the correlation between religiosity and attitudes toward treatment.

Results from this study are similar to some studies about the impact of mental health professionals' religiosity on attitudes toward other populations and treatment needs (Cummings et al., 2014; Kellems et al., 2010; Wade, Worthington, & Vogel, 2007). These studies revealed that mental health professionals' religious/spiritual background did not significantly impact the therapeutic relationship with these populations (Cummings et al., 2014; Kellems et al., 2010; Wade, Worthington, & Vogel, 2007). It is possible that multicultural training may allow some mental health professionals to separate their personal religious belief system from how they view JSO treatment (Crook-Lyon & O'Grady, 2012). Kellems et al.'s (2010) research demonstrated that mental health professionals recognized the need to monitor their countertransference and reactions to client issues that were incongruent with their spiritual/religious viewpoints. It is possible that participants from this study recognize the need for monitoring countertransference when faced with religious/spiritual incongruence. Therefore, training and monitoring countertransference may override the impact religiosity might have on labeling and attitudes toward JSO treatment.

Mental Health Professionals' Gender

The relationship between mental health professionals' gender and attitudes toward JSO treatment is limited to a study conducted by Jones (2013). The lack of research about how mental health professionals' gender impacts the labeling of JSOs and their attitudes toward JSO treatment justified the investigation of this variable. Consistent with findings from Jones (2013), the results from this study did not reveal a statistically significant relationship between mental health professionals' gender and their attitudes

toward JSOs. Only 0.9 % of the variance of attitudes toward JSO treatment was accounted for by gender when controlling for race, training, type of profession, and years of experience. As stated above, the lack of variability in the ATTSO scores could have lowered the correlation coefficient between gender and attitudes toward JSO treatment.

Results from this study also parallel previous research of other treatment populations. Okiishi et al. (2006), Owen et al. (2014), and Wampold and Brown (2005) demonstrated that gender did not impact therapeutic relationships or treatment outcomes. Mental health professionals' ethical codes require them to promote the wellbeing of clients and to protect their needs (Hancock, 2014). Multicultural training emphasizes the need for professionals to be aware of how their cultural factors (e.g. gender, race, religiosity/spirituality) impact their attitudes toward clients, therapeutic relationships, and treatment provision (Middleton, Erguner-Tekinalp, Williams, Stadler, & Dow, 2011). Additionally, individuals who gravitate to these professions often have a genuine interest in helping people, are more open minded and objective, understand their weaknesses/biases, and are willing to learn and change (Pope, 2014). Therefore, it is possible that ethical standards, multicultural training, self-awareness, and a desire to learn and change may override the impact gender might have on attitudes toward JSO treatment.

Religiosity and Attitudes Moderated by Gender

The third research question sought to understand if mental health professionals' religiosity and attitudes toward JSO treatment were moderated by gender. Results from the third model of the hierarchical multiple regression analysis revealed that the

interaction of gender and religiosity did not account for any statistically significant variance of attitudes toward JSO treatment when controlling for the demographic variables of race, training, type of profession, years of experience, gender, and religiosity. Due to the lack of research about these variables, there is nothing to which the findings could be compared. The explanations previously provided for the outcomes of religiosity and gender could apply to the lack of variance in the interaction between the two variables.

Demographic Variables Impact on Attitudes

Examination of the hierarchical regression revealed that model 1 had statistically significant change when the demographic variables were entered. Therefore, the demographic variables of race, training, type of profession, and years of experience were examined to determine how they related to attitudes toward JSO treatment. Only the variables of type of profession and racial identity accounted for a statistically significant portion of the variance in attitudes toward JSO treatment. "Other" mental health professionals' attitudes were significantly more negative than psychologists, counselors/therapists, school psychologists, social workers, and behavioral health providers. Asian participants had more negative attitudes toward JSO treatment than White and Hispanic/Latino participants.

Type of Profession. According to Fortney and Baker (2009), professionals who work with sex offenders have more optimistic views of treatment effectiveness than those who work with victims of sexual abuse. However, this study did not differentiate type of profession of the participants, so it is difficult to determine which professionals held more

positive views (Fortney & Baker, 2009). Another study examined attitudes toward adult sex offenders held by psychologists, psychiatrists, social workers, correction officers, administrators, and individuals in "other" occupations (Engle, McFalls, & Gallaghar, 2007). Results revealed that there were no differences in attitudes among the professionals toward the treatment of sex offenders (Engle et al., 2007). The findings from these research studies are inconsistent with the findings from this study, which revealed that participants in "other" professions held significantly more negative attitudes toward JSO treatment than psychologists, counselors/therapists, school psychologists, social workers, and behavioral health providers. Because I was unable to find studies that analyzed different types of mental health professionals' attitudes toward juvenile sex offender treatment, the attitudes of different types of mental health professionals from this study could not be compared with other literature. However, it is possible participants in the "other" category did not receive training or education that emphasized individual wellbeing and the potential for people to change. For example, behavioral health technicians might not receive education or training that promotes the idea that individuals can change with help, and that all individuals deserve to be treated. The remaining types of professions that held more positive views do receive such training and education.

Racial Identity. Results from this study demonstrated that Asian participants held more negative attitudes than White and Hispanic/Latino participants. Findings from research by Church et al. (2011) revealed there was not a statistically significant relationship between psychology students' attitudes toward adult sex offender treatment

and racial identity. While these results are inconsistent with those found in this study, the Church et al. (2011) study was examining attitudes toward adult sex offender treatment. Additionally, Sahlstrom and Jeglic (2008) were not able to find a statistically significant difference between student participants' racial identity and their attitudes toward JSOs. The population included Hispanic, African-American, Caucasian, Asian, and "Other" participants (Sahlstrom & Jeglic, 2008), which was a similar racial demographic to the participants of this study. However, this study's findings cannot be directly compared to those from the Sahlstrom and Jeglic (2008) study because the researchers used a student participant population. Explaining the findings about race is difficult. Although statistically controlled for during analyses, there was a smaller sample of Asian participants from which to explain the variance. However, Asian cultures emphasize the wellbeing and needs of the group over the individual (Matsumoto, 2001). Perhaps Asian participants believed that JSOs actions promote their own needs above those of the collective "group" and therefore are unworthy of treatment or incapable of change.

Level of Training. Participants' level of training (education level) did not reveal any statistically significance portion of the variance, which is congruent with findings from the study conducted by Nelson et al (2002). Nelson et al. (2002) did not discover any significant difference with extent of training (type of education/degree) and attitudes toward adult sex offender treatment. However, Willis et al. (2013) discovered that participants with higher levels of education held more positive views toward sex offenders. Both of these former studies examined how level of training impacted attitudes toward adult sex offender treatment, making comparisons from this study's

examination of attitudes toward JSO treatment problematic. It may be that mental health professionals are more likely to hold positive views toward treatment outcomes if they receive some form of training that emphasizes all individuals' ability to change, including JSOs.

Experience. The mental health professionals' years of experience did not significantly contribute to the portion of the variance, which is consistent with the results produced by Jones (2013). However, Romero (2014) discovered that more experienced therapists working with JSOs had more positive attitudes about treatment. The findings are also inconsistent with former research that discovered years of experience promoted positive views of adult sex offender treatment success (Nelson et al., 2002; Scheels, 2001). More experienced counselors held more positive views of an adult sex offender's ability to change than counselors with less experience (Nelson et al., 2002; Scheels, 2001). Given that the incongruence of existing literature findings about how years of experience affect attitudes toward JSO treatment, it might be too early to determine why years of experience from this study did not contribute to the variance. It is clear that more research needs to be conducted to determine how this variable might impact attitudes toward JSO treatment.

Labeling Theory and Attitudes Toward Treatment of JSOs

Labeling theory was the theoretical foundation for this study (Becker, 1963). Becker (1963) posited that those in political power or government authority may ascribe a label of "delinquent" or "deviant" to outcasts of society, such as drug addicts, psychiatric patients, and sex offenders (Becker, 1963; Markowitz, Angell, & Greenberg,

2011; Moore & Morris, 2011). Society's views of individuals labeled as deviant become increasingly more negative and impact political agendas that pertain to the deviant individuals' community interactions (Moore & Morris, 2011). Becker (1963) further described how individuals begin to hold inaccurate views of the labeled person, assume the labeled person is incapable of change, and struggle to change their beliefs about the labeled individual even when presented evidence to the contrary. Labeling becomes more problematic when the deviant behaviors become the primary means of identifying the person (Young & Thompson, 2011). Labeled individuals begin to internalize the label, suffer from low self-esteem, reject themselves, and return to criminal or negative behaviors in reaction to the label (Markowitz et al., 2011; Moore & Morris, 2011).

The lens of labeling theory explains how and why individuals form inaccurate beliefs that most sex offenders are deviant and a homogenous group of individuals who cannot be rehabilitated (Church et al., 2011; Cochrane, 2010; Moore & Morris, 2011; Rogers, Hirst, & Davies, 2011; Sahlstrom & Jeglic, 2008; Sun et al., 2011; Worling, 2013). When treatment providers espouse such stereotypical beliefs and labels, it can negatively impact JSO treatment effectiveness and increase the likelihood of recidivism (Blomberg & Bales, 2012; Linn, Grater, & Perersilia, 2010; Mingus & Burchfield, 2012). Therefore, it is essential to understand professionals' beliefs about treatment effectiveness and recidivism (Jones, 2013; Worling & Langton, 2012).

Cummings et al. (2014) found that fundamental or conservative spiritual/religious mental health care workers can carry more negative attitudes toward individuals with deviant or unconventional sexual behaviors. I speculated that these negative attitudes

could be held by participants with higher levels of religiosity and lead to labeling JSOs as incapable of change. However, no relationship was discovered between these two variables. Because previous findings about gender and attitudes toward adult sex offenders are divided (Feguson & Ireland, 2006; Nelson et al., 2002; Tyagi, 2006), I was unable to speculate if men or women would espouse more negative labels about JSO treatment ability. However, there was no statistically significant relationship between gender and attitudes toward JSO treatment. Understanding how labeling theory explains the differences in attitudes among types of professions and racial identities is more difficult due to a lack of research. Howard and Levinson (1985) described that labeling occurs within groups, not individuals, and labeling may depend on the characteristics of the labelers. Therefore, it is possible that some shared characteristics of Asian participants and participants in "other" professions led to more negative labels. The average of all participants' attitudes toward JSO treatment was neither extremely negative nor extremely positive, which indicates that the professionals did not hold extreme labels of JSOs or treatment effectiveness.

Limitations of the Study

External Validity

Although a majority of the participants were contacted through Google searches, LinkedIn, and the Walden participant pool, I also used my membership with the Arizona Psychological Association for recruitment. The survey did not provide an option for participants to indicate where they reside. It is likely that a larger portion of Arizona

professionals responded to the survey, making the results less generalizable to mental health professionals across the globe and decreasing the external validity of the study.

Generalizability could also be threatened because the study was limited to participants who had access to the Internet and understood how to use it. Potential participants who could not access the Internet or did not understand how to use it were automatically eliminated, which could have created selection bias (Ahern, 2005). In addition, due to the sensitive nature of the survey content, some contacted participants may have chosen not to complete the survey. If this occurred, it could have created self-selection bias (Laerd Dissertation, 2012).

Internal Validity

Social desirability bias may have been problematic with this survey study. Although Ahern (2005) stated that anonymous surveys decrease social desirability bias, Krumpal (2013) noted that participants often experience pressure to answer questions in a socially acceptable manner. This can be especially true when questions focus on sensitive topics, such as sex offense behaviors.

This survey was completed via the Internet. Therefore, I could not control the testing environment, data privacy, or who completed the survey. If the survey was completed in a distracting or public environment, inaccurate reporting could have occurred. Although participants' anonymity was secured for the study, they might not have taken steps to ensure their privacy while completing the survey. If participants completed the survey in a location open to public scrutiny, participants may not have answered truthfully. I sent the survey invitation and link to the study only to mental

health professionals, but I had no way to verify that the contacted participant was the person who completed the survey.

Demographic variables were examined in conjunction with gender, religiosity, and attitudes toward JSO treatment. These variables included type of profession, racial identity, years of experience, and training. However, there could be other personal characteristics of the professionals that were not accounted for in this study. Additionally, the survey design did not allow participants who indicated their profession as "other" to specify their type of profession. Therefore, the impact of these participants' professions on their attitudes toward JSO treatment could not be examined.

Construct and Statistical Conclusion Validity

Using the ATTSO for the study could have impacted the results. Original research of the ATTSO demonstrated weak associations between factors and some low Cronbach's alpha coefficients of internal consistency (Church et al., 2011). There is a limited amount of research that validates the psychometric properties of the ATTSO. However, the coefficient alpha for the ATTSO from this study (0.83) indicated good internal consistency (Field, 2013).

Numerous studies have confirmed that the SCSRFQ has good reliability and validity (Cummings et al., 2015; Plante & Boccaccini, 1997a, 1997b; Sherman et al., 2001). Good reliability of the SCSRFQ for this study was confirmed by calculating the coefficient alpha (0.98). However, it is worth noting that using the SCSRFQ may not have provided an accurate measure of how participants interpreted their religiosity.

Many participants contacted me, stating they wish they could have indicated what spiritual or religious belief system they follow.

If I drew the wrong conclusion about the relationships between mental health professionals' religiosity and gender and their attitudes toward JSOs, conclusion validity could be a limitation of this study. I sought to decrease conclusion errors by using the recommended statistical power and increased effect size to improve interpretations of the results (Field, 2013).

Recommendations for Future Research

Due to some of the limitations of this study, the characteristics of gender and religiosity should be further explored. The impact of mental health professionals' gender on attitudes toward JSO treatment has only been examined in one other study. Jones (2013) did not find a significant difference between participants' gender on the overall score of the CATSO survey, but he did find that males had slightly (although not statistically significant) more positive views of JSO treatment than females. Because research has demonstrated gender impacts mental health professionals' attitudes and treatment provision for other populations (Artoski & Saarnio, 2013; Ferguson & Ireland, 2006; Greeson et al., 2009; Nelson, 2007; Saarnio, 2010; Tyagi, 2006), this variable should be further explored as it relates to JSO treatment.

Because religiosity greatly impacts individuals' behaviors and attitudes, it is imperative to understand how this variable impacts mental health professionals (Balkin, et al, 2009; Cummings et al., 2014; Farkas, 2014; Kellems et al., 2010). One of the aforementioned limitations of this study was the use of the SCSRFQ. Some participants

expressed that they felt as if they could not answer all of the questions because some questions did not pertain to their belief system, or they stated that the survey questions were too restricted to those who espouse more "mainline" religious/spiritual practices. Therefore, another survey instrument could be used to examine religiosity/spirituality among mental health professionals.

There is limited research regarding how mental health professionals' personal characteristics impact their attitudes toward JSO treatment. Given the importance of how treatment providers' attitudes affect JSO treatment, future research should focus on other characteristics of mental health professionals that may impact their attitudes. For example, the provider's political orientation, type of employment organization (e.g. prison, outpatient treatment, private practice, etc.), and age could be factors worthy of research.

Recruiting from a geographically broader sample of mental health providers would also be a direction for future researchers. Using mental health participants from various areas of the country or globe would allow the findings to be more generalizable. A more racially diverse sample could also allow for further analysis of how racial identity impacts attitudes toward JSO treatment. Additionally, future researchers could add an optional testing environment that would not require participants to understand or have access to the Internet. This could decrease selection bias that can be problematic with "Internet only" studies, and the results could be more generalizable.

It is recommended that future researchers alter the demographic questionnaire. They could ask participants who indicate "other" as their type of profession to identify

their specific occupation. This would provide more defined information about the "other" type of profession from which to make comparisons to other research about various mental health professionals.

Finally, it would be advantageous to use other survey instruments to assess the variables of religiosity and attitudes toward sex offender treatment. Some participants experienced the SCSRFQ as limiting and unrepresentative of how to describe their belief system. Potentially more problematic was the ATTSO, which has limited reliability and validity. Another survey I considered using to assess attitudes was the Community Attitudes Toward Sex Offenders scale (CATSO; Church et al., 2008), which has been cross-validated and demonstrates stronger reliability and validity than the ATTSO. However, the CATSO has not been validated for use with attitudes toward juvenile offenders. Prior to an official research study, a pilot study would need to be conducted to analyze the psychometric properties of the CATSO as it is applied to JSOs.

Implications

Results from this study can provide mental health professionals deeper insight into characteristics that might impact their attitudes toward JSO treatment. Although it was impossible to determine which types of professions were included in the "other" category of professions, the findings do reveal that there are individuals in some types of mental health professions with more negative attitudes toward JSO treatment than other mental health professionals. Findings also revealed that racial identity is related to attitudes toward JSO treatment. Therefore, mental health professionals should consider if

and how their profession and racial identity might impact their attitudes toward JSO treatment.

Training

Training programs can help increase professionals' awareness of how their racial identity and type of profession might impact their beliefs or attitudes toward JSO treatment. Because treatment effectiveness is influenced by the provider's attitudes and therapeutic relationship (Carone & LaFleur, 2000; Jones, 2013; Nelson, 2007; Sahlstrom & Jeglic, 2008; Salerno et al., 2010), training programs must address labels, negative attitudes, and personal characteristics that may negatively affect the providers' attitudes and therapeutic relationships with JSOs (Worling, 2012). Training programs need to promote mental health professionals' ability to look at all possible hindrances to effective treatment.

Impact for Social Change

It is important that JSO treatment follow the initiative of the juvenile justice system – rehabilitation (Sahlstrom & Jeglic, 2008). A focus on rehabilitation promotes effective treatment, which can decrease JSO recidivism rates (Calleja, 2013; Cochrane, 2010; Waite, Keller, & McGarvey, 2005). Providers who possess negative attitudes toward treatment hinder its effectiveness (Nelson, 2007; Wakefield, 2006; Worling & Langton, 2012). Mental health professionals who believe JSO treatment is effective and develop a healthy relationship with the offender are more likely to witness positive responses and changes in the JSO (Carone & LaFleur, 2000; Jones 2013; Worling, 2012). A JSO is more likely to adhere to treatment when a healthy therapeutic relationship

exists, which can potentially decrease the likelihood that the JSO will reoffend (Jones, 2013; Waite et al., 2005; Worling, 2012). This decrease in recidivism increases protection of the public, and it also promotes the JSO's wellbeing (Nelson, 2007; Sahlstrom & Jeglic, 2008; Salerno et al., 2010).

Conclusion

Although the results from this study did not indicate relationships between mental health professionals' gender and religiosity and their attitudes toward JSO treatment, the study revealed that type of profession and racial identity were related to attitudes. There continues to be a lack of research about how the personal characteristics of mental health professionals affect their attitudes toward JSO treatment. This study attempted to respond to this lack of research, but the results did not significantly expand the existing literature. The researcher hopes that the explanation of the limitations and the recommendations for future research will promote studies aimed at broadening our current knowledge of what impacts mental health professionals' attitudes toward JSO treatment.

References

American Psychological Association. (2014). *Ethical principles of psychologists and code of conduct*. Retrieved from http://www.apa.org/ethics/code/index.aspx

Ahern, N. R. (2005). Using the Internet to conduct research. *Nurse Researcher*, *13*(2), 55-70. doi: 10.7748/nr2005.10.13.2.55.c5968

Artkoski, T. & Saarnio, P. (2013). Therapist's gender and gender roles: Impact on attitudes toward clients in substance abuse treatment. *Journal of Addiction, 2013*, 1-6. doi: 10.1155/2013/591521

Balkin, R. S., Schlosser, L. Z., & Levitt, D. H. (2009). Religious identity and cultural diversity: Exploring the relationships between religious identity, sexism, homophobia, and multicultural competence. *Journal of Counseling & Development, 87*(4), 420-427. doi: 10.1002/j.1556-6678.2009.tb00126.x

Beatty, A. E., Hull, M., & Arikawa, H. (2007). Correlates of therapist's religious attitude and conservatism. *Mental Health, Religion, & Culture, 10*(5), 527-535. doi: 10.1080/13670601105982

Becker, H. (1963). *Outsiders: Studies in the sociology of deviance*. Glencoe, IL: Free Press.

Bidell, M. P. (2014). Personal and professional discord: Examining religious conservatism and lesbian, gay, and bisexual affirmative counselor competence. *Journal of Counseling & Development, 92*(2), 170-179. doi: 10.1002/j.1556-6676.2014.00145.x

Blomberg, T. G., & Bales, W. D. (2012). Is educational achievement a turning point for incarcerated delinquents across race and sex? *Journal of Youth Adolescence*, *41*(2), 202- 216. doi: 10.1007/s10964-011-9680-4

Buchner, A., Faul, F., & Erdfelder, E. (n.d.). G*Power. Retrieved from http://www.psycho.uni-duesseldorf.de/abteilungen/aap/gpower3/download-and-register/Dokumente/GPower3-BRM-Paper.pdf

Caldwell, M. F., & Dickinson, C. (2009). Sex offender registration and recidivism risk in juvenile sexual offenders. *Behavioral Sciences and the Law*, *27*(6), 941-956. doi: 10.1002/bsl.907

Calleja, N. G. (2013). Integrating research into practice: The Forward-Focused Model of adolescent sexual behavior treatment. *Aggression and Violent Behavior, 18*(6). 686-694. doi: 10.1016/j.avb.2013.07.023

Carone, S. S. & LaFleur, N. K. (2000). The effect of adolescent sex offender abuse history on counselor attitudes. *Journal of Addictions & Offender Counseling, 20*(2), 56-63. doi:10.1002/j.2161-1874.2000.tb00142.x

Chaffin, M. (2008). Our minds are made up - Don't confuse us with the facts: Commentary on policies concerning children with sexual behavior problems and juvenile sex offenders. *Child Maltreatment*, *13*(2), 110-121. .doi: 10.1177/1077559508314510

Cheung, M., & Brandes, B. J. (2011). Enhancing treatment outcomes for male adolescents with sexual behavior problems: Interactions and interventions. *Journal of Family Violence*, *26*(5), 387-401. doi:10.1007/s10896-011-9373-5

Church, W. T., Sun, F., Li, X. (2011). Attitudes toward the treatment of sex offenders: A SEM analysis. *Journal of Forensic Social Work, 1*(1), 82-95. doi: 10.1080/1936928X.2011.541213

Cochrane, D. (2010). *Attitudes towards Megan's law and juvenile sex offenders* (Doctoral dissertation). Retrieved from http://digitalscholarship.unlv.edu/thesesdissertations/2

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hilldale, NJ: Lawrence Erlbaum Associates, Publishers.

Conley, T., Hill, K., Church, W. T., Stoeckel, E., & Allen, H. (2011). Assessing probation and community corrections workers' attitudes toward sex offenders using the Community Attitudes Toward Sex Offenders (CATSO) scale in a rural state. *Sexual Addiction & Compulsivity, 18*(2), 75-85. doi: 10.1080/10720162.2011.582775

Connor, D. P. (2012). Prison wardens' perceptions of sex offenders, sex offender registration, community notification, and residency restrictions. Unpublished Master's Thesis. University of Louisville, Louisville, KY.

Crook-Lyon, R. E. & Frietas, G. (2010). Working with clients who have religious/spiritual issues. *Journal of College Student Psychotherapy, 24*(2), 139-155. doi: 10.1080/87568220903558745

Crook-Lyon, R. E. & O'Grady, K.A. (2012). Addressing religious and spiritual diversity in graduate training and multicultural education for professional psychologists. *Psychology of Religion and Spirituality, 4*(3), 169-181. doi: 10.1037/a0026403

Cummings, J. P., Carson, C. S., Shrestha, S., Kunick, M. E., Amento, M. E., Stanley, M. A., Amspoker, A. B. (2015). Santa Clara Strength of Religious Faith Questionnaire: Psychometric analysis in older adults. *Aging & Mental Health, 19*(1), 86-97. doi: 10.1080/13607863.2014.917606

Cummings, J. P., Ivan, M. C., Carson, C. S., Stanley, M. A., & Paragment, K. I. (2014). A systematic review of relations between psychotherapist religiousness/spirituality and therapy-related variables. *Spirituality in Clinical Practice,1*(2), 116 –132 . doi: 10.1037/scp0000014

Engle, M. J., McFalls, J. A., & Gallaghar, B. J. (2007). The attitudes of the members of the Association for the Treatment of Sexual Abusers towards treatment, release, and recidivism of violent sex offenders: An exploratory study. *Journal of Offender Rehabilitation, 44*(4), 17-24. doi: 10.1300/J076v44n04_02

Farkas, M. A. (2014). The potential of research to inform theory, policy, and practice. *International Journal of Offender Therapy and Comparative Criminology*, *58*(4), 391-393. doi: 10.1177/0306624X14522392

Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? *Journal of Offender Rehabilitation, 18*(3-4), 217-223. doi: 10.1300/J076v18n03_16

Ferguson, K. & Ireland, C. A. (2006). Attitudes towards sex offenders and the influence of offence type: a comparison of staff working in a forensic setting and students. *The British Journal of Forensic Practice, 8*(2), 10-19. doi: 10.1108/1463664620060009

Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th ed.).London: Sage.

Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles who commit sex offenses against minors. Juvenile Justice Bulletin. doi: https://www.ncjrs.gov/pdffiles1/ojjdp/227763.pdf

Fortney, T. & Baker, J. N. (2009). A look in the mirror: Sexual abuse professionals' perceptions about sex offenders. *Victims and Offenders, 4*(1), 42-57. doi: 10.1080/15564880802561754

Freiheit, S. R., Sonstegard, K., Schmitt, A., & Vye, C. (2006). Religiosity and spirituality: A psychometric evaluation of the Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 55*(1), 27-33. doi: 10.1007/s11089-006-0029-y

Greeson, J. K. P., Guo, S., Barth, R. P., Hurley, S., & Sisson, J. (2009). Contributions of therapist characteristics and stability to intensive in-home therapy youth outcomes. *Research on Social Work Practice, 19*(2), 239-250. doi: 10.1177/1049731508329422

Halse, A., Grant, J., Thornton, J., Indermaur, D., Stevens, G., & Chamarette, C. (2012). Intrafamilial adolescent sex offenders' response to psychological treatment. *Psychiatry, Psychology, and Law, 19*(2), 221-235. doi: 10.1080/13218719.2011.561763

Hancock, K. A. (2014). Student beliefs, multiculturalism, and client welfare. *Psychology of Sexual Orientation and Gender Diversity, 1*(2), 4–9. doi:10.1037/sgd0000021

Hayes, T. A. (2010). Labeling and the adoption of a deviant status. *Deviant Behavior*, *31*(3), 274-302. doi: 10.1080/01639620903004861

Hecker, L. L., Trepper, T. S., Wetchler, J. L., & Fontaine, K. L. (1995). The influence of therapist values, religiosity and gender in the initial assessment of sexual addiction by family therapists. *American Journal of Family Therapy, 23*(3), 261-272. doi: 10.1080/01926189508251356

Ikomi, P. A., Harris-Wyatt, G., Doucet, G., & Rodney, H. E. (2009). Treatment for juveniles who sexually offend in a Southwestern state. *Journal of Child Sexual Abuse*, *18*, 594-610. doi: 10.1080/10926770903307914

Jones, E. C. (2013). An examination of counseling professionals/paraprofessionals attitudes toward adolescent sexual offenders. *Sage Open*, *3*(3), 1-14. .doi: 10.1777/2158244013501330

Jung, S., Jamieson, L., Buro, K., & Descare, J. (2012). Attitudes and decisions about sexual offenders: A comparison of laypersons and professionals. *Journal of Community & Applied Social Psychology*, *22*, 225-238. doi:10.1002/casp.1109

Kellems, Hill, Crook-Lyon, R. E. & Frietas, G. (2010). Working with clients who have religious/spiritual issues: A survey of university counseling center therapists. *Journal of College Student Psychotherapy, 24*(2), 139-155. doi: 10.1080/87568220903558745

Kimonis, E. R., Fanniff, A., Borum, R., & Elliott, K. (2010). Clinician's perceptions of indicators of amenability to sex offender-specific treatment in juveniles. *Sexual Abuse: A Journal of Research and Treatment*, *23*(2), 193-211. doi: 10.1177/1079063210384278

Krumpal, I. (2013). Determinants of social desirability bias in sensitive surveys: A

literature review**.** *Quality & Quantity: International Journal of Methodology, 4*7(4), 2025-2047. doi: 10.1007/s11135-011-9640-9

Self-selection Sampling. (2012). Retrieved from http://dissertation.laerd.com/self-selection-sampling.php#ad-dis

Lease, S. H., Horne, S. G., Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for Caucasian lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology, 52*, 378-388. doi: 10.1037/0022-0167.52.3.378

Letourneau, E. J., Henggeler, S. W., McCart, M. R., Borduin, C. M., Schewe, P. A., & Armstrong, K. S. (2013). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. *Journal of Family Psychology, 27*(6), 978-985. doi: 10.1037/a0034710

Linn, J., Grater, R., & Peresilia, J. (2010). "Back-end sentencing" and re-imprisonment: Individual, organizational, and community predictors of parole sanctioning decisions. *Criminology*, *48*(3), 759-795. doi: 10.1111/j.1745-9125.2010.00201.x

Mann, R. E. & Barnett, G. D. (2013). Victim empathy intervention with sexual offenders rehabilitation, punishment, or correctional quackery? *Sexual Abuse: A Journal of Research and Treatment, 25*(3), 282-301. doi: 10.1177/1079063212455669

Markowitz, F. E., Angell, B., & Greenberg, J. S. (2011). Stigma, reflected appraisals, and recovery outcomes of mental illness. *Social Psychology Quarterly*, *74*(2), 144-165. doi: 10.1177/0190272511407620

Matsumoto, D. (2001). *The handbook of culture and psychology*. New York, NY: Oxford

University Press.

Middleton, R. A., Ergüner-Tekinalp, B., Wiliams, N. F., Stadler, H. A., Dow, J. E. (2011). Racial identity development and multicultural counseling competencies of white mental health practitioners. *International Journal of Psychology and Psychological Therapy, 11*(2) 201-218. Retrieved from http://www. ijpsy. com

Mingus, W., & Burchfield, K. (2012). From prison to integration: Applying modified labeling theory to sex offenders. *Criminal Justice Studies: A Critical Journal of Crime, Law, and Society*, *25*(1), 97-109. doi: 10.1080/1478601X.2012.657906

Moore, M., & Morris, M. B. (2011). Political science theories of crime and delinquency. *Journal of Human Behavior in the Social Environment*, *21*(3), 284-296. doi: 10.1080/10911359.2011.564953

Nelson, M. (2007). Characteristics, treatment, and practitioners perceptions of juvenile sex offenders. *Journal for Juvenile Justice Services, 21*(1/2), 7-16. Retrieved from http://search.proquest.com.ezp.waldenulibrary.org/criminaljusticeperiodicals/docview/613692243/abstract/E48E1668F3C7425CPQ/2?accountid=14872

Nelson, M., Herlihy, B., & Oescher, J. (2002). A survey of counselor attitudes towards sex offenders. *Journal of Mental Health Counseling, 24*(1), 51-67. doi: 10.1177/1049731507310193

Okiishi, J. C., Lambert, M. J., Eggett, D., Neilsen, Dayton, D. D., & Bermeersch, D. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*(9), 1157-1172. doi: 10.1002/jclp.20272

Owen, J., Duncan, B., Reese, R. J., Anker, M., & Sparks, J. (2014). Accounting for therapist variability in couple therapy outcomes: What really matters? *Journal of Sex & Marital Therapy, 40*(6), 488-502. doi: 10.1080/0092623X.2013.772552

Plante, T. G. & Boccaccini, M. (1997a). The Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 45*(5)*,* 375-387.

Plante, T. G., & Boccaccini, M. T. (1997b). Reliability and validity of the Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology*, *45*(6), 429–437.

Plante, T. G., Vallaeys, C. L., Sherman, A. C., & Wallston, K. A. (2002). The development of a brief version of the Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 50*(5), 359-368.

Plante, T. G., Yancey, S., Sherman, A., Guertin, M., & Pardini, D. (1999). Further validation for the Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology*, *48*(1), 11–21.

Pope, M. (2014). Who controls the training of new mental health professionals? *Psychology of Sexual Orientation and Gender Identity, 1*(2), 90-92. doi: 10.1037/sgd0000025

Pullman, L. & Seto, M. C. (2012). Assessment and treatment of adolescent sexual offenders: Implications of recent research on generalist versus specialist explanations. *Child Abuse & Neglect, 36*(3), 203-209. doi: 10.1016/j.chiabu.2011.11.003

Rasmussen, L. A. (2012). Trauma outcome process assessment (TOPA) model: An ecological paradigm for treating traumatized sexually abusive youth. *Journal of Child & Adolescent Trauma, 5*(1), 63-80. doi: 10.1080/19361521.2012.646645

Rogers, P., Hirst, L., & Davies, M. (2011). An investigation into the effect of respondent gender, victim age, and perpetrator treatment on public attitudes towards sex offenders, sex offender treatment, and sex offender rehabilitation. *Journal of Offender Rehabilitation*, *50*(8), 511-530. doi: 10.1080/10509674.2011.602472

Romero, L. R., (2014). *An investigation into attitudes toward the treatment of juvenile sex offenders* (Doctoral dissertation). Available from ProQuest Dissertations & Theses Full Text database. (UMI No. 3629514)

Saarnio, P. (2010). Big five personality traits and interpersonal functioning in female and male substance abuse therapists. *Substance Use and Misuse, 45*(10), 1463-1473. doi: 10.3109/10826081003749963

Sahlstrom, K. S. & Jeglic, E. L. (2008). Factors affecting attitudes toward juvenile sex offenders. *Journal of Child Sexual Abuse, 17*(2), 180-196. doi: 10.1080/10538710801916705

Salerno, J. M., Najdowski, C. J., Stevenson, M. C., Wiley, T. R., Bottoms, B. L., Varca, R., & Pimentel, P. M. (2010). Psychological mechanisms underlying support for juvenile sex offender registry laws: Prototypes, moral outrage, and perceived threat. *Behavioral Sciences & the Law*, *28*(1), 58-83. doi: 10.1002/bsl.906

Sandhu, D. K., & Rose, J. (2012). How do therapists contribute to therapeutic change in sex offender treatment: An integration of the literature. *Journal of Sexual*

Aggression, *18*(3), 269-283. doi: 0.1080/13552600.2011.566633

Sanghara, K. K., & Wilson, J. C. (2006). Stereotypes and attitudes about child sexual abusers: A comparison of experienced and inexperienced professionals in sex offender treatment. *Legal and Criminological Psychology, 11*(2), 229-244. doi: 10.1348/135532505X68818

Scheela, R. A. (2001). Sex offender treatment: Therapists' experiences and perceptions. Issues of Mental Health Nursing, 22(8), 749-767. doi: 10.1080/01612840152713009

Seto, M.C., & Lalumiere, M. L., (2010). What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. *Psychology Bulletin, 136*(4), 526-575. doi: 10.1037/a0019700

Sherman, A. C., Simonton, S., Adams, D. C., Latif, U., Plante, T. G., Burns, S. K., Poling, T. (2001). Measuring religious faith in cancer patients: Reliability and construct validity of the Santa Clara Strength of Religious Faith Questionnaire. *Psycho-Oncology*, *10*(5)*,* 436–443. doi: 10.1002/pon.523

Sherman, A. C., Plante, T. G., Simonton, S., Adams, D. C., Burris, S. K., & Harbison, C. (1999). Assessing religious faith in medical patients: Cross-validation of the Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology 48*(2), 129-141. Retrieved from Walden University library databases

Skitka, L. J., Bauman, C.W., & Mullen, E. (2004). Political tolerance and coming to psychological closure following September 11, 2001, terrorist attacks: An integrative approach. *Personality and Social Psychology Bulletin, 30*(6), 743-

756. doi: 10.1177/0146167204263968

Stevenson, M. C., Sorenson, K. M., Smith, A. C., Sekely, A., & Dzwairo, R. A. (2009) Effects of defendant and victim race on perceptions of juvenile sex offenders. *Behavioral Sciences and the Law, 27*(6), 957-979. doi: 10.1002/bsl.910

Survey Monkey (2015). Security statement. Retrieved from https://www.surveymonkey.com

Tewksbury, R. & Mustaine, E. E. (2013). Law-enforcement officials' views of sex offender registration and community notification. *International Journal of Police Science & Management, 15*(2), 95-113. doi: 10.1350/ijps.2013.15.2.305

Trochim, W. K. (2006). Statistical power. Retrieved from http://www.socialresearchmethods.net/kb/power.php

Tyagi, S. V. (2006). Female counselors and male perpetrators of violence against women. Women & Therapy, 29(1/2), 1-22. Doi: 10.1300/J015v29n01_01

Wade, N. G., Worthington E. L., Jr., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research, 17,* 91–105. doi:10.1080/10503300 500497388

Waite, D., Keller, A., & McGarvey, E. L. (2005). Juvenile sex offender re-arrest rates for sexual, violent nonsexual and property crimes: A 10-year follow-up. *Sexual Abuse: Journal of Research and Treatment, 17(i),* 313-331. doi: 10.1007/s11194-005-5061-4

Wakefield, H. (2006). The vilification of sex offenders: Do laws targeting sex offenders increase recidivism and violence? *Journal of Sexual Offender Civil Commitment:*

Science and the Law, 1, 141-149. Retrieved from http://www.soccjournal.org/2005-06/Wakefield_2006.pdf

Wampold, B. E. & Brown, G. (2005). Estimating therapist variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*(5), 924-923. doi: 10.1037/0022-006X.73.5.914

Willis, G. M., Malinen, S., Johnston, L. (2013). Demographic differences in public attitudes towards sex offenders. *Psychiatry, Psychology, and Law, 20*(2), 230-247. doi: 10.1080/13218719.2011.658206

Wnuk, D., Chapman, J. E., & Jeglic, E. L. (2006). Development and refinement of a measure of attitudes toward sex offender treatment. *Journal of Offender Rehabilitation, 43*(3), 35-47. doi: 10.1300/J076v43n03_03

Worling, J. R. (2013). What were we thinking? Five erroneous assumptions that have fueled specializations for adolescents who have sexually offended. *International Journal of Behavioral Consultation and Therapy*, *8*(3-4), 80-88. Retrieved from http://files.eric.ed.gov/fulltext/EJ1017936.pdf

Worling, J. R., & Langton, C. M. (2012). Assessment and treatment of adolescents who sexually offend: Clinical issues and implications for secure settings. *Criminal Justice and Behavior*, *39*(6), 814-841. doi:10.1177/0093854812439378

Yoder, J. R. (2014). Service approaches for youths who commit sexual crimes: A call for family-oriented models. *Journal of Evidence-Based Social Work, 11*(4), 360-372. doi: 10.1080/10911359.2014.897108

Young, R. L., & Thompson, C. Y. (2011). Gender, attributions of responsibility, and negotiation of deviant labels in small groups. *Deviant Behavior*, *32*(7), 626-652. doi: 10.1080/01639625.2010.514203

Appendix A: Demographic Form

Demographic Information Form

Instructions: Please provide a response for each of the following questions:

1.What is your gender?

Female ○ Male ○

2. Type of profession:

Psychologist ○ Counselor/Therapist ○ Psychiatrist ○

School Psychologist ○ Social Worker ○

Behavioral Health Provider ○

Other ○

3. Your primary racial identity:

○ Black or African American

○ Asian
○ White
○ Hispanic or Latino
○ Alaska Native or American Indian
○ Native Hawaiian/ Pacific Islander
○ Other: _____

4. Years of Experience:

○ 1 - 2 years
○ 3 - 5 years
○ 6 - 10 years
○ 10 - 20 years
○ 20 + years

5. Level of training/education?

- Bachelors
- Masters
- Doctoral

5. How did you hear about this survey?

- Walden Participant Pool
- Linked In
- Email

6. Have you already taken this survey?

- Yes
- No

Appendix B: The Santa Clara Strength of Religious Faith Questionnaire

The Santa Clara Strength of Religious Faith Questionnaire

Primary Reference: Plante, T.G., & Boccaccini, M. (1997). The Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 45,* 375-387

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree

_____ 1. My religious faith is extremely important to me.

_____ 2. I pray daily.

_____ 3. I look to my faith as a source of inspiration.

_____ 4. I look to my faith as providing meaning and purpose in my life.

_____ 5. I consider myself active in my faith or church.

_____ 6. My faith is an important part of who I am as a person.

_____ 7. My relationship with God is extremely important to me.

_____ 8. I enjoy being around others who share my faith.

_____ 9. I look to my faith as a source of comfort.

_____ 10. My faith impacts many of my decisions.

Appendix C: The Attitudes Toward the Treatment of Sex Offenders Scale

ATTSO SCALE

The statements listed below describe different attitudes toward the treatment of sex offenders in the United States. There are no right or wrong answers, only opinions. You are asked to express your feelings about each statement by indicating whether you (1) Disagree strongly, (2) Disagree, (3) Undecided, (4) Agree, or (5) Agree strongly. Indicate your opinion by writing the number that best describes your personal attitude in the left-hand margin. Please answer every item.

Rating Scale

1	2	3	4	5
Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly

1. I believe that sex offenders can be treated. _____
2. Treatment programs for sex offenders are effective. _____
3. It is better to treat sex offenders because most of them will be released. _____
4. Most sex offenders will not respond to treatment. _____
5. People who want to work with sex offenders are crazy. _____
6. Psychotherapy will not work with sex offenders. _____
7. I believe that all sex offenders should be chemically castrated. _____
8. Regardless of treatment, all sex offenders will eventually reoffend. _____
9. Treating sex offenders is a futile endeavor. _____
10. Sex offenders can be helped using the proper techniques. _____
11. Treatment doesn't work, sex offenders should be incarcerated for life. _____

12. Only certain types of sex offenders will respond to treatment. _____
13. Right now, there are no treatments that work for sex offenders. _____
14. It is important that all sex offenders being released receive treatment. _____
15. We need to urge our politicians to make sex offender treatment mandatory. _____
16. All sex offenders should go for treatment even if they don't want to. _____
17. Sex offenders who deny their crime will not benefit from treatment. _____
18. Treatment only works if the sex offender wants to be there. _____
19. Sex offenders don't deserve another chance. _____
20. Tax money should not be used to treat sex offenders. _____
21. Sex offenders don't need treatment since they chose to commit the crime(s). _____
22. A sex offender whose crime is rape offends because he is violent. _____
23. Treatment is only necessary for offenders whose victims are children. _____
24. Treatment funding should be focused on the victims, not on the offenders. _____
25. Sex offenders should be executed. _____
26. Sex offenders should never be released. _____
27. Most sex offenders serve over 10 years in prison for their crime. _____
28. The prison sentence sex offenders serve is enough, treatment is not necessary. _____
29. Treatment is not necessary because everyone in the community knows who the sex offenders are. _____

30. Civilly committing sex offenders to treatment facilities is a violation of their rights. _____
31. Treatment should be conducted during incarceration. _____
32. Sex offenders are the worst kind of offenders. _____
33. Sex offenders should not be released back into the community. _____
34. A sex offender is like any other offender, no special treatment is necessary. _____
35. Treatment of sex offenders should be completed within a year. _____